MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2005

Celtic Insurance Company
233 South Wacker Drive, Suite 700
Chicago, IL 60606-6393

NAIC Company Code 80799

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS
FOR
COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

Celtic Insurance Company
233 South Wacker Drive, Suite 700
Chicago, IL 60606-6393

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2005

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

April 24, 2007

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Celtic Insurance Company was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205, 10-3-1106, and 10-16-216, C.R.S., which authorize the Commissioner of Insurance to examine health insurers. We examined the Company's records at its office located at 233 South Wacker Dr., Suite 700, Chicago, IL 60606-6393. The market conduct examination covered the period from January 1, 2005 through December 31, 2005.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
CELTIC INSURANCE COMPANY

TABLE OF CONTENTS

COMPANY PROFILE

Celtic Insurance Company (hereinafter referred to as "Celtic" or "Company") is domiciled in the State of Illinois. Frederick J. Manning, the ultimate controlling person, holds 100% ownership in Celtic Capital. Celtic Capital and Celtic Associates each have 50% ownership in Celtic Investment Group (CIG). Celtic Group Inc. (CGI) is a wholly-owned subsidiary of CIG and holds 100% ownership of Celtic Insurance Company.

In 1980, CGI formed a 50/50 partnership named CIG with Celtic Associates to purchase an 80% stake in Resolute Investment Corporation (RIC), which included American Reserve Life Insurance Company (ARLIC). At that time, ARLIC was renamed Celtic Life Insurance Company. In the mid 1980's, CIG purchased the remaining 20% of RIC. Subsequently, RIC merged into CGI, which was owned by CIG, and Celtic Capital became a 50/50 partner in CIG. In 1990, Celtic changed its domicile state from Rhode Island to Illinois. In 1999, Celtic Life Insurance Company changed its name to Celtic Insurance Company.

During 2005, Celtic contracted with Affiliated Computer Services, Inc. (ACS), a third party administrator, to assume customer service, document management, claims adjudication and payment, member enrollment and billing, and related information systems support duties beginning in early 2006 for the majority of its product lines.

The Company is licensed in the District of Columbia and in all states except New York. Currently, Celtic is selling individual products in thirty-seven (37) states.

*The Company's 2005 total accident and health direct written premium in Colorado was $3,423,000, which represents 0.05% of the market share.

*Data as reported in the 2005 Colorado Insurance Industry Statistical Report.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (Division), in accordance with §§ 10-1-203 and 10-1-204, C.R.S., which empower the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Celtic Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of this limited market conduct examination was to determine the Company's compliance with Colorado insurance laws related to individual sickness and accident insurance. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the limited examination in accordance with procedures developed by the Division based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The market conduct examination covered the period from January 1, 2005 through December 31, 2005.

The limited examination included review of the following:

Company Operations and Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations/Rescissions
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the

examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-203, C.R.S.	Authority, scope, and scheduling of examinations.
Section 10-1-204, C.R.S.	Conduct of examinations.
Section 10-1-205, C.R.S.	Financial examination reports.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-104.5, C.R.S.	Autism – treatment – not mental illness.
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage.
Section 10-16-105.5, C.R.S.	Individual health plans – federally eligible individual – limited guarantee issue.
Section 10-16-106.3, C.R.S.	Uniform claims – billing codes – electronic claim forms.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-106.7, C.R.S.	Assignment of health insurance benefits.
Section 10-16-107, C.R.S.	Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-112, C.R.S.	Private utilization review – health care coverage entity responsibility.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-123, C.R.S.	Telemedicine.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans – repeal.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-203, C.R.S.	Optional provisions in individual sickness and accident insurance policies.
Section 10-16-703, C.R.S.	Applicability.

Section 10-16-704, C.R.S.	Network adequacy.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Section 10-20-102, C.R.S.	Legislative declaration.
Section 10-20-119, C.R.S.	Prohibited advertisement of association article in insurance sales – notice to policyholders.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act"
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-1	Replacement of Accident and Sickness Insurance
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning The Definition of The Term "Complications of Pregnancy" For Use In Accident And Health Insurance Policies
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Insurance Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Insurance Regulation 4-6-5	Concerning The Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-9	Concerning Conversion Coverage

Company Operations and Management

The examiners reviewed Company management and administrative controls, the certificate of authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following applications, policy forms, endorsements, riders, and other forms:

FORM NUMBER	FORM NAME	
15-585-00167-CO	CeltiCare Application	2/04
15-585-00167-CO	Celtic Basic Application	5/06
I5-543-00150-CO	CeltiCare Policy	12/02
I5-544-00159-CO	Celtic Basic Policy	01/03
EM 28 53 (01-02)-SEBG-CO	Determination of Self-Employed Business Group of One	
No Form Number	Colorado Standard Health Plan Description Form	
ERTime803.doc Rev 8/03	Elimination Rider For Specified Condition(s)	
ERPerm803.doc	Permanent Elimination Rider For Specified Condition(s)	
Ardelins803.doc Rev 8/03	Amendatory Rider Change of Primary Applicant	
I5591-00188 1/05	Amendatory Rider	
I5-714-00072	Colorado Mandated Individual Conversion Plan Standard Indemnity Plan	
I5-716-00073B	Colorado Mandated Individual Conversion Plan Standard PPO Plan	
No Form Number	Certification Of Individual Health Insurance Coverage	
I5-905-00058-CO RFCO 7/03	Notice To Applicant Regarding Replacement of Accident and Sickness Insurance	

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files selected in the Applications section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period.

Applications

The Company furnished a population of seventy-three (73) policies issued with restrictive riders and a random sample of fifty (50) files that were issued in 2005 with these riders was chosen using ACL ™ software. The Company does not consider its individual policies as renewing, but indicates continuing coverage is at the discretion of the insured; therefore, the Company makes no distinction between new business and renewal business. The Company furnished data indicating a population of 416 policies issued and in-force in 2005. For these policies that were issued or in-force during the period from January 1, 2005 through December 31, 2005, the examiners used ACL ™ software to randomly select fifty (50) individual files. The files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations/Rescissions

For individual applicants that were declined during 2005, the Company provided data reflecting eighty-two (82) files and for policies that were rescinded in 2005, the Company provided data reflecting two (2) files. A population of 754 cancelled files was provided and the examiners used ACL ™ software to randomly select fifty (50) declined files and fifty (50) cancelled files for review. The total population of two (2) rescinded files was also reviewed.

Claims

The data provided by the Company indicated that claim files during 2005 were all received non-electronically. The examiners used ACL ™ software to randomly select samples of the non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in both of these categories were included as one issue.

The examiners used ACL ™ software to randomly select samples of 100 paid claims and 100 denied claims that were reviewed for the Company's overall claims handling practices. In the interest of expediting the examination the samples for both the paid and the denied claims were subsequently reduced to fifty (50) each.

The Company had 297 claim files processed by Health Plan Services (HPS) for closed blocks of business during 2005. A sample of fifty (50) of these paid and denied claim files was randomly selected using ACL ™ software to be reviewed for both processing and timeliness of payment, denial or settlement.

Utilization Review

The Company uses Encompass Health Management Systems to perform utilization review on their behalf. ACL ™ software was used to randomly select fifty (50) files from the population of 178 files involving utilization review decisions during 2005. The total population of five (5) appeal files was also reviewed.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-eight (38) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified two (2) areas of concern in their review of company operations and management:

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Issue A2: Failure to provide a complete response to a request for claims records.

Policy Forms: The examiners identified twenty-four (24) areas of concern in their review of the most frequently sold individual coverage forms and conversion policies in use during the year under examination:

Issue E1: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.

Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.

Issue E3: Failure to reflect the mandatory coverage to be provided for prosthetic devices.

Issue E4: Failure to include notification of the availability and a description of the independent external review procedures in or attached to policies.

Issue E5: Failure to allow benefits for covered services based on a licensed provider's status, (e.g., a family member or normally a member of the insured's or the insured dependent's household.)

Issue E6: Failure to provide credit for previous coverage for certain named conditions.

Issue E7: Failure to reflect the mandatory coverage to be provided for low-dose mammography.

Issue E8: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

Issue E9: Failure to reflect all required information in application forms concerning replacement of coverage.

Issue E10: Failure to reflect accurate requirements to qualify as a dependent.

Issue E11: Failure to reflect the mandatory coverage for child health supervision services.

Issue E12: Failure to maintain a Colorado health plan description form required to be provided to business groups of one applying for coverage.

Issue E13: Failure to accurately reflect the coverage to be offered for home health services and hospice care.

Issue E14: Failure to reflect the mandated coverage to be provided for the treatment of cleft lip and cleft palate.

Issue E15: Failure to reflect correct or complete information on certificates of creditable coverage.

Issue E16: Failure to use one of the three required Basic health benefit plan design options as conversion coverage.

Issue E17: Failure to include accurate benefits and coverage wording in the Standard PPO health benefit policy.

Issue E18: Failure to include accurate benefits and coverage wording in the Standard indemnity health benefit policy.

Issue E19: Failure to accurately reflect the required and optional provisions in individual sickness and accident policies.

Issue E20: Failure to reflect correct eligibility requirements for conversion coverage.

Issue E21: Failure to reflect correct deductible amounts, coinsurance percentages and plan type titles on the conversion coverage application.

Issue E22: Failure to reflect only allowable exclusions for coverage of complications of pregnancy.

Issue E23: Failure to include a provision for continuity of care in applicable instances involving termination of coverage.

Issue E24: Failure to reflect the correct number of days allowed for a break in coverage for the purpose of giving credit for previous creditable coverage.

Rating: The examiners found no areas of concern in their review of the rates and associated required rate filings.

Applications: The examiners identified five (5) areas of concern in their review of the application files:

Issue G1: Failure, in some cases, to issue health insurance policies with exclusionary riders that comply with Colorado insurance law.

Issue G2: Failure, in some cases, to provide CoverColorado notice forms in instances involving a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.

Issue G3: Failure, in some cases, to provide a replacement notice when replacing another policy of accident and sickness insurance.

Issue G4: Failure to use required determination and disclosure forms to allow exemption from provisions required of small group plans when offering and issuing individual plans to business groups of one.

Issue G5: Failure to comply with Colorado insurance law by issuing conversion policies for other carriers.

Cancellations/Non-Renewals/Declinations: The examiners identified two (2) areas of concern in their review of cancellations/non-renewals/declinations/rescissions:

Issue H1: Failure to provide CoverColorado notice forms in all required instances.

Issue H2: Failure, in some cases, to reflect correct information in certificates of creditable coverage.

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some cases, to pay, deny or settle claims within the required time periods.

Issue J2: Failure to pay late payment interest and penalties in applicable cases.

Issue J3: Failure, in some cases, to accurately process claims.

Utilization Review: The examiners found two (2) areas of concern in their review of utilization review procedures:

Issue K1: Failure to reflect complete standards or definitions in utilization review policy and procedure documents.

Issue K2: Failure to have written notification of benefit denials signed by a licensed physician.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

CELTIC INSURANCE COMPANY

COMPANY OPERATIONS AND MANAGEMENT FINDINGS

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law on all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company in 2005 were in compliance with statutory mandates as evidenced by issues E1 through E24 of the market conduct examination report.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all policy forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified by an officer of the Company, and as required by Colorado insurance law.

Issue A2: Failure to provide a complete response to a request for claims records.

Colorado Insurance Regulation 1-1-8, Penalties and Timelines Concerning Division Inquiries and Document Requests, promulgated pursuant to §§ 10-1-109, 10-2-104, 10-3-109(3), and 10-16-109, C.R.S., states in part:

Section 4 Definitions

As used in this regulation:

D. "Examination Request/Comment Form" means a request for information made during the course of a formal market conduct or financial examination under §§ 10-1-201 to 207, C.R.S., and includes: 1) A written request from the examiner for books, records, materials, information, or data necessary for examination of the company's operations; and 2) A written comment from the examiner which identifies concerns related to company actions and requires additional information or acknowledgment from the company.

Section 5. Rules

A. Unless another time period is specified by the Division in writing, every person shall provide a *complete response to Examination Request*/Comment Forms within ten (10) calendar days from the date on the form.

C. If additional time is required to respond to any Division inquiry, the person shall submit a request for an extension of time in writing to the Division employee or examiner making the inquiry. The request for an extension of time shall be made within the original response period established in this regulation, and shall state in detail the reasons necessitating the extension. Extensions are granted at the discretion of the Division for good cause shown. When a request for extension is granted, the person shall respond within the new time period granted. If an extension is not granted, the person shall respond within ten (10) calendar days of the notice that the extension was not granted, and is subject to the imposition of appropriate penalties from the original due date.

The population of claims provided to the examiners and developed from the Company's system, reflected that the submission type for all claims received in 2005 had been other than electronic; i.e., "paper". As a result, it was not necessary or possible to conduct a timeliness study for claims received electronically.

However, during the review of a sample of claim files provided by the Company, some of the files included a note that read: "EDI Claim – Electronically submitted claim – No claim form image." This prompted inquiries between the examiners and the Company which resulted in the determination that the Company had actually received 358 electronically submitted claims in 2005. However, it appeared that the Company failed to identify these claims as having been electronically received in its records, which resulted in no electronic claims being included in the claims data provided to the examiners. Therefore, the Company failed to provide a complete response to the examination request for the Company's claims data.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that complete records required for market conduct purposes are maintained and can be provided for examination purposes in compliance with Colorado insurance law.

POLICY FORMS
FINDINGS

Issue E1: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.

Section 10-1-128, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states in part:

> (6)(a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:
>
> **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

The Company has indicated that it uses its application forms to provide the fraud statement required by Colorado insurance law. The fraud statement on the application forms does not appear to be in compliance with Colorado insurance law as the wording is not substantially the same as reflected in the law.

The wording on the application forms is:

> **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Form Number	Form Name
15-585-00167-CO APO8CO 2/04	CeltiCare Application
15-585-00167-CO AP11CO 5/06	Celtic Basic Application

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-1-128, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that the fraud statement included on its application forms is substantially the same as what is required by Colorado insurance law.

Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.

Section 10-16-704, C.R.S., Network adequacy, states in part:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence and availability of the access plan.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its health benefit plans do not clearly disclose the existence and availability of an access plan for its managed care networks.

Form Number	Form Name
I5-543-00150-CO	CeltiCare - Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic - Major Medical Expense Policy

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all health benefit plans clearly disclose the existence and availability of an access plan as required by Colorado insurance law.

Issue E3: Failure to reflect the mandatory coverage to be provided for prosthetic devices.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(14) Prosthetic devices

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, and 13951, and 1395m and 42 CFR 414.202, 414.210, 414.228 and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) *Repairs and replacements of prosthetic devices are also covered*, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added.]

The description of coverage for prosthetic devices in the Company's two (2) major medical expense policies appears to be more limiting than the mandatory coverage required by Colorado insurance law in the following way:

- Coverage is limited to the *initial* replacement of artificial limbs or eyes *that are lost while an insured person's coverage is in force*.

Unless necessitated by misuse or loss, all replacements are to be covered, and coverage may not be limited to only those prosthetic devices needed to replace limbs that are lost while an insured person's coverage is in force.

The wording on page 15 of the policies is as follows:

SECTION IV – BENEFITS

Eligible Expenses

MEDICAL SUPPLY CHARGES for the following medical supplies:

- Initial artificial limbs or eyes needed to replace natural limbs or eyes that are lost while an *insured person's* coverage is in force;

Form Number	Form Name
I5-543-00150-CO	CeltiCare - Major Medical Expense Policy
I5-543-00159-CO	Celtic Basic - Major Medical Expense Policy

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for prosthetic devices required by Colorado insurance law.

Issue E4: Failure to include notification of the availability and a description of the independent external review procedures in or attached to policies.

Section 10-16-113.5, C.R.S., Independent external review of benefit denials – legislative declaration – definitions, states in part:

> (6) All health coverage plan materials dealing with the plan's grievance procedures *shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.* [Emphasis added.]

Colorado Insurance Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states in part:

> Section 5. Notice and Disclosure of Right to External Review
>
> B. (1) Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures *in or attached to* all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. [Emphasis added.]
>
> (2) The description required under (1) of this Subsection B *shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.* [Emphasis added.]

The Company does not appear to be in compliance with Colorado insurance law which requires notification with a complete description of the external review procedures to be in or attached to all health coverage plan materials dealing with the plan's grievance procedures. A paragraph on page 22 of both major medical expense policies reads:

> **Claim Appeal Process**
>
> Though claim submissions are treated fairly based on the facts surrounding the loss, some claim decisions need further review. A claimant may have additional information which could change the decision or may want a review of the decision.
>
> There is an appeal process to provide a full and fair review of the proof of loss. All appeals must be submitted in writing within 60 days of the date *we* send notice to *you.*

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113.5, C.R.S. and Colorado Insurance Regulation 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that notice and complete disclosure of the right to an external review is included in or attached to all health coverage plans as required by Colorado insurance law.

Issue E5: Failure to allow benefits for covered services based on a licensed provider's status, (e.g., a family member or normally a member of the insured's or the insured dependent's household.)

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (7) Reimbursement of providers.
>
> (a) Sickness and accident insurance.
>
> (I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* [Emphasis added.]

The Company's individual major medical expense policies used in Colorado in 2005 and the Standard indemnity and PPO Plans used by the Company in its "Conversion Program", reflect an exclusion that does not appear to be in compliance with Colorado insurance law. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., a family member, or any person in an insured dependent's family, or normally a member of the insured person's household.)

Wording on page 7 of the CeltiCare and Celtic Basic policies states:

> A *physician* does **NOT** include someone who is related to an *insured person* by blood, marriage or adoption or who is normally a member of the insured person's household.
>
> *Nurse* means a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) who is providing care prescribed by a *physician.* This definition does **NOT** include someone who is related to an insured person by blood, marriage, adoption, or who is normally a member of the *insured person's* household.

Wording on page 20 (Standard Indemnity Plan) and page 22 (Standard PPO Plan) states:

> **Limitations**

Covered Charges will not include and no benefits will be paid for:
the services of any person in your Immediate Family, or any person in your Dependent's Immediate Family;

Wording on page 18 of the Standard Indemnity Plan states:

Home Health Care

The general Comprehensive Medical limitations listed in this Section will apply to Home Health Care. In addition, Comprehensive Medical Covered Charges will not include charges for:

b. the services of any person who normally lives in your or your Dependent's home

Form Number	Form Name
I5-543-00150-CO	CeltiCare – Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic – Major Medical Expense Policy
I5-714-00072	Colorado Mandated Individual Conversion Plan Standard Indemnity Plan
I5-716-00073B	Colorado Mandated Individual Conversion Plan Standard PPO Plan

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that reimbursement for covered services provided by a licensed provider who normally charges for services is not denied based solely upon the providers status as required by Colorado insurance law.

Issue E6: Failure to provide credit for previous coverage for certain named conditions.

Section 10-16-102, C.R.S., Definitions, states in part:

(13.7) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare or Medicaid;
(b) An employee welfare benefit plan or group health insurance or health benefit plan;
(c) An individual health benefit plan;
(d) A state health benefits risk pool (including but not limited to CoverColorado); or
(e) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" (22 U.S.C. Sec 2504 (e)).

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. …

The Company's two (2) major medical expense policies do not appear to be in compliance with Colorado insurance law in that they exclude coverage for six (6) months for surgical treatment of certain named conditions, and do not provide credit for previous coverage. Time delaying coverage or benefits for certain conditions (not covered during the first six months of a policy) is not allowed under Colorado insurance law as it has the ability, and suggests the intent, to avoid giving credit for previous coverage towards pre-existing condition exclusions.

The wording in the policies on page 19 is as follows:

SECTION V – EXCLUSIONS AND LIMITATIONS

Exclusions

Benefits will **NOT** be paid for *incurred* charges for the following:

- Surgical treatment of tonsils, adenoids, hernia, myringotomy, or dilation and curettage if performed within six (6) months of the effective date.

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy

Recommendation No.8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that certain named conditions are not temporarily excluded, and that credit for prior coverage is provided towards any pre-existing condition limitations as required by Colorado insurance law,.

Issue E7: Failure to reflect the mandatory coverage to be provided for low-dose mammography.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(4) Low-dose mammography

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. *Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index.* Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. [Emphasis added.]

The Company's two (2) major medical expense policies appear to reflect an incorrect minimum benefit for low-dose mammography. The minimum benefit mandated by Colorado insurance law is the lesser of a specified amount (adjusted annually to reflect increases and decreases in the consumer price index) per mammography screening or the actual charge for such screening. This minimum benefit has exceeded the $77.00 reflected in the Company's policies since September 1, 2003, as indicated below:

$81.73 from September 1, 2004 through August 31, 2005
$85.16 from September 1, 2005 through August 31, 2006

The Company's policies reflect the following wording:

Page 14 of the CeltiCare Policy and Page 15 of the Celtic Basic Policy

SECTION IV – BENEFITS

Eligible Expenses

MEDICAL SERVICE CHARGES for the following medical services:

- Coverage for screening by low-dose mammography as follows:
- one baseline mammogram for an *insured person* age 35 through 39: and
- one mammogram per *calendar year* for an *insured person* age 40 and over or more often as recommended by a physician;

Covered charges will be the lesser of [$77] per screening or the actual charge for the screening. The deductible will not apply.

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has corrected all applicable forms to provide the minimum benefit for low-dose mammography as required by Colorado insurance law.

Issue E8: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (1.7) Therapies for congenital defects and birth abnormalities
>
> (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children *up to five years of age*. [Emphasis added.]
>
> (b) The level of benefits required in paragraph (a) of this subsection (1.7) *shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy*. [Emphasis added.] Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

The Company's two (2) major medical expense policies that were examined do not appear to reflect an accurate description of the therapies mandated by Colorado insurance law for congenital defects and birth abnormalities for covered children in the following ways:

- The coverage for medically diagnosed congenital birth defects and birth abnormalities is reflected in the "Eligibility" section under the heading of "Newborn Children". There is no indication in the policies that this coverage is to be provided for covered children up to five years of age.

- Under the "Benefits" section of the CeltiCare policy, under the heading of "Medical Service Charges", outpatient rehabilitation therapy is limited to thirty (30) visits per calendar year for outpatient rehabilitation therapy. The level of benefits required by Colorado insurance law is the greater benefit, (which is required), and consists of twenty (20) visits per year for each of the three types of therapy. This corresponds to a total of sixty (60) visits per calendar year.

The policies reflect the following wording:

On page 14 of the CeltiCare Policy and on page 9 of the Celtic Basic Policy

SECTION I – DEFINITIONS

> **Rehabilitation Therapy** means services provided to restore a bodily function after an *insured person's sickness* or *bodily injury*. It includes occupational therapy, acupuncture, physical therapy and speech therapy.

On page 9 of the CeltiCare Policy and on Page 10 of the Celtic Basic Policy

SECTION II – ELIGIBILITY

Newborn Children

> Children born to an *insured person* while this policy is in force will be insured without evidence of insurability from the moment of birth for an initial 31 day period. Coverage will include the necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities. …

Page 14 of the CeltiCare Policy provides:

SECTION IV – BENEFITS

Eligible Expenses

> **MEDICAL SERVICE CHARGES** for the following medical services:
>
> - Up to [30] visits per calendar year for outpatient rehabilitation therapy

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that an accurate description of the mandated therapies for children with congenital defects and birth abnormalities is reflected in all its policies as required by Colorado insurance law.

Issue E9: Failure to reflect all required information in application forms concerning replacement of coverage.

Colorado Insurance Regulation 4-2-1, Replacement of Accident and Sickness Insurance, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.), states in part:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

A. Application forms *shall include* the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such *questions and statements* may be used.

[Statements]

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits? [Emphases added.]

The Company's insurance application forms do not appear to reflect required statements (3) and (4), nor question (3) which makes pertinent information available to persons considering replacement of their coverage. No supplementary application or other form reflecting this information was provided to the examiners.

Form Number	Form Name
15-585-00167-CO APO8CO 2/04	CeltiCare Application
15-585-00167-CO AP11CO 5/06	Celtic Basic Application

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all required information concerning replacement of coverage is reflected in its insurance application forms as required by Colorado insurance law.

Issue E10: Failure to reflect accurate requirements to qualify as a dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "*Dependent*" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is *financially dependent* upon the parent, and *an unmarried child of any age who is medically certified as disabled and dependent upon the parent.* [Emphases added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (6) Dependent children.
>
> (b) No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that the child:
>
> (I) Does not live in the home of the parent applying for the policy;
>
> (6.5) Adopted child – dependent coverage.
>
> (a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, regardless of whether adoption of the child is final.
>
> (c) For the purposes of this subsection (6.5), unless the context otherwise requires:
>
> (I) "Child" means a person who has not attained eighteen years of age.
>
> (II) "*Placed for adoption"* means circumstances under which a *person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption*. A placement terminates at the time such legal obligation terminates. [Emphases added.]

The CeltiCare and Celtic Basic individual health care plans used by the Company do not appear to reflect accurate requirements for qualifying as a dependent in the following ways:

- Colorado insurance law doesn't include a requirement that the child(ren) of the Insured receive *principal* support from the primary insured person to qualify as a dependent.

- Colorado insurance law does not require an adoption to be final (legally adopted) or that an adopted child be in the custody of the primary insured person for the child to be eligible for coverage. Adopted children are eligible for coverage when "placed" for adoption (a legal obligation to partially or totally support a child in anticipation of the final adoption) rather than when the adoption is complete and the child is placed in the home of the insured person.

- Colorado insurance law defines a disabled dependent as being medically certified as disabled and dependent upon the parent. A dependent that is medically certified as disabled cannot have the limiting condition attached of being *"principally"* dependent upon the insured parent for support and maintenance.

The wording on page 4 of the CeltiCare and the Celtic Basic policies is:

> DEFINITIONS
>
> *Dependent* is a lawful spouse or unmarried child of the *primary insured person*. Unmarried *dependent* child includes step-child, legally adopted child and child in the custody of the *primary insured person* as a result of an interim court order of adoption.

The wording on page 9 of the CeltiCare policy and page 10 of the Celtic Basic policy is:

> SECTION II - ELIGIBILITY
>
> To be eligible as a *dependent* the child(ren) must meet the definition of *dependent*, be under 25 years of age and be principally dependent on the *primary insured person* for the majority of their support and maintenance. *Your dependen*ts who are incapable of earning their own living due to a handicapped condition are eligible for coverage regardless of age. *We* reserve the right to request reasonable proof of their continuing condition while coverage is in force.

The wording on page 21 of the policies is:

> SECTION III – THE HEALTHCARE CERTIFICATION PROGRAM
>
> - Handicapped Child
>
> Medical expense plan coverage can be continued for a child who is unable to earn his own living because of a handicapped condition and is principally dependent on the *primary insured person or other care providers* for total care and supervision.

The Colorado Standard Indemnity and PPO Plans used by the Company in its "Conversion Program" do not appear to reflect accurate requirements for qualifying as a dependent in the following ways:

- Colorado insurance law does not require that children receive principal support from the primary insured person to qualify as a dependent.

- There is no requirement that an insured's stepchild be approved by the Company in writing to qualify as a dependent.

- Colorado insurance law does not require a stepchild to reside with the primary insured to be eligible as a dependent. Additionally, there is no requirement that the stepchild be principally supported by the insured.

- A full-time student cannot have the limiting condition attached of receiving principal support from the parent.

Pages 9 and 10 of the Standard Indemnity and the Standard PPO policies state:

> PART II - ELIGIBLITY
>
> To be eligible as a dependent the child(ren) must meet the definition of dependent, be under 19 years of age *and be principally dependent on the primary insured person for the majority of their support and maintenance.* Your dependents who are incapable of earning their own living due to a handicapped condition are eligible for coverage regardless of age. We reserve the right to request reasonable proof of their continuing condition while coverage is in force.

Pages 35 and 36 of the Standard Indemnity Policy and pages 37 and 38 of the Standard PPO Policy state:

> **Dependent**
>
> c. Your stepchild or foster child, if that child:
>
> (1) Meets the requirements in b. (1), (2), (3) and (4) above;
>
> (2) Receives principal support from you;
>
> (3) Is approved by Us in writing as a dependent; and
>
> (4) Lives with you except that a stepchild not living with you will be eligible if:
>
> - you are under a court ordered medical support obligation;
>
> - the child receives principal support from you; and
>
> - the child is approved by Us in writing as a dependent.
>
> d. A child 19 years but less than 24 years of age who otherwise qualifies under b. or c. above, if that child receives principal support from you and is an Active Full-Time Student.

Form Number	Form Name
I5-543-00150-CO	CeltiCare – Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic – Major Medical Expense Policy
I5-714-00072	Colorado Mandated Individual Conversion Plan Standard Indemnity Plan
I5-716-00073B	Colorado Mandated Individual Conversion Plan Standard PPO Plan

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all its policies reflect accurate requirements to qualify as a dependent as required by Colorado insurance law.

Issue E11: Failure to reflect the mandatory coverage for child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105(7.2), to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. …

(c) Benefits for child health supervision services *shall be exempt from a* deductible or *dollar limit provision in any individual*, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and *such exemption shall be explicitly stated in such a plan.* [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Attachment 1

Covered Preventive Services [1]	
All Children	Immunizations. (Covered immunizations are listed at the end of this document.) Immunization deficient children are not bound by "recommended ages" on immunization chart.
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	5 well-child visits [2]
	1 PKU
Age 13-35 months	2 well-child visits
Age 3-6	3 well-child visits
Age 7-12	3 well-child visits

2 "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.) and growth and development assessment. For older children, this also includes safety and health education counseling.

The benefits for Child Health Supervision Services that are reflected in the Company's individual major medical expense policies and the Amendatory Rider used with both plans do not appear to reflect correct or complete coverage for child health supervision services to be provided for children up to age thirteen (13).

Incomplete description of the mandated benefits in both policies:

- There is no description of the benefits in the policies other than to state that the deductible does not apply to preventive care services. Additionally, the policy for the Celtic Basic plan specifically reflects routine care services under the plan's Exclusions and Limitations.

- Nothing is reflected concerning the coverage of one newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery.

Incomplete description of the mandated benefits in Celtic Basic Policy:

- There is neither a list of covered immunizations nor a statement that immunizations are based on the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

- Nothing is reflected to alert insureds that immunization deficient children are not bound by the recommended ages on the immunization chart.

- There is no information concerning coverage of 1 PKU during age 0-12 months.

Incorrect description of the mandated benefits in both policies:

- Child health supervision service benefits are reflected as a preventive care service in the Celtic Basic Policy. A rider attached to this policy amends this section with a requirement that preventive services are covered after coverage has been in effect for a selected number of months. (The sample rider provided by the Company reflects what appears to be a bracketed-adjustable 12 months). Colorado insurance law does not require coverage to have been in effect for any number of months before this mandated benefit is to be provided.

- The amendatory rider used with both policies reflects that the Preventive Care Benefit has a policy year maximum amount covered of up to $200 per insured person, this does not correspond to the statutory requirement that this benefit shall be exempt from a dollar limit provision.

The wording on page 8 of both the CeltiCare and the Celtic Basic Policies is as follows:

SECTION I – DEFINITIONS

Note: Italicized words are defined in this policy.

Preventive Care means immunizations, examinations and diagnostic tests recommended and administered for the purpose of early detection of illness in an *asymptomatic individual.*

The wording on page 15 of the CeltiCare and page 16 of the Celtic Basic policies is as follows:

- CHILD HEALTH SUPERVISION SERVICES for preventive services and immunizations to dependent children up to age thirteen (13) under the supervision of a single physician, physician's assistant, or registered nurse. Coverage is limited to one visit payable to one provider for all the services provided at each visit. The deductible does not apply to benefits for preventive care services.

The wording on page 18 of the Celtic Basic policy is as follows:

SECTION V – EXCLUSIONS AND LIMITATIONS

Definitions, other plan provisions, or plan benefits may further limit payments; therefore, this section cannot be solely relied upon to determine when benefits are NOT payable:

Exclusions

Benefits will **NOT** be paid for incurred charges for the following:

- Routine physical examinations, immunizations, newborn nursery charges and routine well-baby care, of a *dependent child*, unless required by state law. Well-baby care is defined as charges not related to a *sickness or bodily injury*.

The wording on the amendatory rider to the Celtic Basic policy is as follows:

PREVENTIVE CARE BENEFIT: After coverage has been in force for [twelve months], eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered up to [$200] per insured person per calendar year. The annual deductible does not apply.

Preventive Care Benefits include, but are not limited to, charges for the following:

- Annual physical examinations, including office visits;

- Routine x-rays, labs and diagnostic tests;
- Screening services such as colorectal cancer tests, bone mass measurement and cardiovascular and diabetes tests; and
- Immunizations.

Preventive Care charges in excess of the *calendar year* maximum are not *eligible expenses.*

Form Number	Form Name
I5-543-00150-CO	CeltiCare – Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic – Major Medical Expense Policy
I5-591-00188 1/05	Amendatory Rider

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that coverage for child health supervision services are accurately reflected in its policies and riders as required by Colorado insurance law.

Issue E12: Failure to maintain a Colorado health plan description form required to be provided to business groups of one applying for coverage.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states in part:

> (1)(c)(I) The provisions of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:
>
> (D) … The individual carrier shall provide to the business group of one self-employed applicant *a copy of the health benefit plan description form for the Colorado standard health benefit plan* in addition to the description form for the individual plan being marketed. [Emphasis added.]

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

> 5. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:
>
> 4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:
>
> (b) *The carrier must provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans,* available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-16-105.2(1)(c)(I)(D), C.R.S. [Emphasis added.]

The Company has indicated that it did not create, and therefore could not provide, a copy of a Colorado health plan description form for the Standard health benefit plan to be provided to business groups of one applying for coverage during 2005.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-105.2, C.R.S. and Colorado Insurance Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that a Colorado health plan description form is maintained and provided to business groups of one applying for coverage as required by Colorado insurance law.

Issue E13: Failure to accurately reflect the coverage to be offered for home health services and hospice care.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) Sickness and accident insurance

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

(8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section 26-4-103(6), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

(II) "Hospice care" means *hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment* pursuant to sections 25-1.5-103(1)(a)(I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program. [Emphasis added.]

(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state *unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care* which have been recommended by a physician as medically necessary. … [Emphasis Added.]

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions *which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care.*

[Emphasis added.] Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.

Section 4. Requirements for Home Health Services

A. Definitions.

(2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

(c) Medical supplies, *equipment and appliances suitable for use in the home*; and

(d) Physical therapy, occupational therapy or speech pathology and audiology services, as such therapy and services are defined in C.R.S. [Emphases added.]

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. *Services of up to 4 hours by a home health aide shall be considered as one visit.* [Emphasis added.]

(4) "Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization.

Prior hospitalization shall not be required.

C. Benefits for Home Health Care Services.

(2) The policy or certificate may contain a limitation on the number of home health visits, *but no policy offered may provide for fewer than 60 home health visits in any calendar year*. [Emphasis added.]

(3) The policy offered shall include benefits for the following services:

(e) Speech therapy and *audiology*;

(h) *Medical social services;*

(j) Prosthesis and *orthopedic appliances*; [Emphases added.]

Section 5. Requirements for Hospice Care

A. Definitions

(1) A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. *Hospice service shall be provided in the home, a licensed hospice, and/or other licensed health facility*. [Emphasis added.] Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.

(12) "Home care services" are hospice services, *which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(15) "Hospice levels of care:"

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

(16) "Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

(20) An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

B. General Provisions Pertaining to Hospice Care.

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, *except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.* [Emphasis added.]

(4) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team*: [Emphasis added.]

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services; and;

(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control of symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

Section 6. Additional Requirements for Home Health Care Services and Hospice Care

A. The offer to a policyholder to purchase home health care and hospice care coverage *must be in writing, either by means of a prominent statement or question on the application for the policy or on a separate form.* [Emphasis added.]

The Company's CeltiCare and Celtic Basic policies do not to appear to reflect correctly and completely the extent of coverage to be offered for home health services and hospice care in the following ways:

HOSPICE CARE

Incorrect

- The definition section of the CeltiCare policy reflects the following general exclusion for a physician and the definition of Hospice Services also reflects this exclusion for services provided by someone who is related to an insured person by blood, marriage or adoption or who is normally a member of the insured person's household. Hospice services may include the services of a physician. A policy could contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services nor can a policy deny reimbursement for covered benefits based upon the provider's status, e.g., related to an insured person by blood marriage or adoption or who is normally a member of the insured person's household.

- Both of the policies reflect a maximum coverage amount of $5,000 per an insured person's lifetime for hospice care services and supplies and indicate that hospice care services and supplies are limited to charges incurred while in a hospital. There is no definition of a hospice in the policies and this maximum coverage amount is reflected as an eligible hospital expense.

Incomplete

- There is no definition of a "family" in the policies which for hospice services is one unit of care consisting of not only the immediate family, but the primary care giver and individuals with significant personal ties. This would come into play with the benefits to be provided for bereavement support services for the family of the deceased person.

- Nothing is reflected concerning the fact that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

- Nothing is reflected concerning the "Inpatient hospice respite care", one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.

- Nothing is reflected to indicate that bereavement support services for the family of the deceased are to be provided for twelve months following death and in no event shall this maximum benefit be less than $1,150.

- Nothing is reflected to indicate that a "benefit period" for hospice care services is a period of three (3) months, during which services are provided on a regular basis.

- Nothing is reflected to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

- Nothing is reflected to indicate that a benefit of no less than $100 is to be provided per day for three (3) routine home care services and the total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

- Nothing is reflected to indicate that benefits allowed only for individuals who have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. Additionally, after the exhaustion of three (3) benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care.

- Nothing is reflected to identify the twelve (12) benefits (except for bereavement support services) which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

HOME HEALTH SERVICES

Incorrect

- The definition section of the CeltiCare policy reflects the following general exclusion for a physician and the definition of Home Health Care Services also reflects this exclusion for services provided by someone who is related to an insured person by blood, marriage or adoption or who is normally a member of the insured person's household. Home Health Care Services are required to include the services of registered nurses, psychologists, services at the recommendation of and rendered pursuant to a physician's order, all individuals who would have to be licensed to render services. A policy could contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services nor can a policy deny reimbursement for covered benefits based upon the provider's status, e.g., related to an insured person by blood marriage or adoption or who is normally a member of the insured person's household.

Incomplete

- Nothing is reflected indicating that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization or that prior hospitalization shall not be required.

- Nothing is reflected to indicate that "audiology" is a service for which benefits are provided.

- Nothing is reflected to indicate that "medical social services" are services for which benefits are provided.

- Nothing is reflected to indicate that "orthopedic appliances" are covered benefits.

The Company's two (2) policies being used for conversion coverage, the Standard PPO Plan and the Standard Indemnity Plan, do not to appear to reflect correctly and completely the extent of coverage to be provided for home health services and hospice care services in the following ways:

HOSPICE CARE

Incomplete

- Does not reflect that a patient is defined as having an anticipated life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. Additionally, after the exhaustion of three (3) benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care.

- Nothing is reflected concerning the fact that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

- Nothing is reflected to indicate that a "benefit period" for hospice care services is a period of three (3) months, during which services are provided on a regular basis.

- Nothing is reflected to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

- Nothing is reflected to indicate that a benefit of no less than $100 is to be provided per day for three (3) routine home care services and the total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

- Nothing is reflected to indicate that the twelve (12) benefits (except for bereavement support services) are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

Incorrect

- Incorrectly limits the benefit of short-term general inpatient (acute) hospice care or continuous home care for a period of crisis, pain control or symptom management to a lifetime maximum of 30 days. Colorado insurance law does not provide for a lifetime maximum number of days for this benefit.

- Reflects an incorrect period for bereavement support services, (three months), an incorrect maximum benefit ($1,077) and is more limiting than allowed by Colorado insurance law as to who (immediate family) may receive these services. The period for the benefit is twelve months, the maximum benefit is $1,150 and a patient/family is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties. The policy includes a definition of "Immediate Family" as insured person's mother, father, sister, brother, spouse, or child(ren).

- The policy reflects a definition of an Episode of Hospice Care, (corresponding to a "benefit period"), that is incorrect. A "benefit period" for hospice care services is a period of three months, not six months.

- There is no requirement in Colorado insurance law for "benefit periods" of hospice care services to be separated by a period of at least three months during which no hospice care program is in effect for the individual.

HOME HEALTH SERVICES

Incomplete

- Nothing is reflected concerning that there may not be a limitation of less than 60 home health visits in any calendar year.

- Nothing is reflected to indicate that "orthopedic appliances" are covered benefits under home health care or elsewhere in the policy.

- Nothing is reflected to indicate that services up to 4 hours by a home health aide shall be considered as one visit.

Incorrect

- The policy incorrectly defines a Home Health Care Plan (which includes skilled nursing facility confinement) as one that follows a period of hospital confinement and is a result of the sickness or injury that was the cause of the hospital confinement. Prior hospitalization is not required by Colorado insurance law.

Page 5 of the CeltiCare and the Celtic Basic policies reflects:

SECTION I – DEFINITIONS

Italicized words are defined in this policy.

Home health care does **NOT** include services provided by someone who is related to an *insured person* by blood, marriage or adoption or who is normally a member of the *insured person's* household.

Page 6 of the CeltiCare Policy reflects:

SECTION I – DEFINITIONS

Italicized words are defined in this policy.

Hospice services do **NOT** include services provided by someone who is related to an *insured person* by blood, marriage or adoption or who is normally a member of the *insured person's* household.

Page 13 of the CeltiCare Policy and page 14 of the Celtic Basic Policy reflect:

Eligible Expenses

HOSPITAL CHARGES for medical services and supplies *incurred* by an *insured person* while *hospital confined* up to the maximum of the average semi-private *room and board* charge in that *hospital*. For *intensive care*, the maximum *eligible expense* is four times the average semi-private room charge. The following *hospital* charges are examples of *eligible expenses*:

- Up to [$5,000] per an insured person's lifetime for hospice care services and supplies

Page 19 of the Standard PPO policy and page 16 of the Standard Indemnity policy reflect the following:

Skilled Nursing Facility Confinement

Covered Charges will include charges by a Skilled Nursing Facility for room, board and other services required for treatment, provided the confinement:

b. follows Hospital confinement or a prior Skilled Nursing Facility confinement for which benefits were payable under this Section; and

c. results from the sickness or injury that was the cause of Hospital confinement.

Covered Charges for each day will not be more than 50% of:

a. The actual room charge (if the Hospital confinement was in semi-private room); or

b. The Hospital Room Maximum (if the Hospital confinement was in a private room); of the Hospital in which you or your Dependent was confined before the Skilled Nursing Facility confinement.

Hospice Care

Covered Charges will include per diem charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency or Skilled Nursing Facility for:

a. any sick or injured individual (Insured or Dependent) who, in the opinion of the attending Physician, has no reasonable prospect of cure; and

Page 20 of the Standard PPO policy and page 17 of the Standard Indemnity policy reflect the following under Hospice Care:

d. bereavement support services for the insured person's Immediate Family during the three month period following the insured person's death to a maximum benefit of $1,077.

Pages 38 and 39 of the Standard PPO policy and pages 36 and 37 of the Standard Indemnity Policy reflect:

Episode of Hospice Care

Means the period of time:

(1) beginning on the date a Hospice Care Program is established for a dying individual; and

(2) ending on the earlier of: the date six months after the date of Hospice Care Program is established, the date the attending Physician withdraws approval of the Hospice Care Program, the date the individual recovers, or the date the individual dies.

Two or more Episodes of Hospice Care for the same individual will be considered one Episode of Hospice Care, unless separated by a period of at least three months during which no Hospice Care Program is in effect for the individual.

Page 41 of the Standard PPO policy reflects the following under Part XI – Definitions:

Immediate Family

An insured person's mother, father, sister, brother, spouse, or child(ren).

Page 40 of the Standard PPO policy reflects the following under Part IX – Definitions:

Home Health Care Plan

A program of home care that:

(2) follows a period of Hospital confinement;

(3) is the result of the sickness or injury that was the cause of the Hospital Confinement

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy
I5-716-00073B	Colorado Mandated Individual Conversion Policy Standard PPO Plan
I5-714-00072	Colorado Mandated Individual Conversion Policy Standard Indemnity Plan

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that the required coverage to be offered for home health services and hospice care is accurately reflected in all its policies as required by Colorado insurance law.

Issue E14: Failure to reflect the mandated coverage to be provided for the treatment of cleft lip and cleft palate.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (1) Newborn children
>
> (II)(A) With regard to newborn children born with cleft lip or cleft palate or both, *there shall be no age limit on benefits for such conditions,* and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and *follow-up care by plastic surgeons* and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. [Emphases added.]

The description of "Eligible Expenses" in both the Celticare and the Celtic Basic Major Medical Expense policies appear to reflect an incomplete description for benefits available for children born with cleft lip or cleft palate or both. There is no indication that there shall be no age limit on benefits for such conditions. The description of coverage in both the conversion plans, the Standard PPO and the Standard Indemnity, reflect inaccurate coverage for the treatment of cleft lip, cleft palate or both as the description does not indicate any of the specific benefits to be provided or that there is no age limit on benefits for such conditions. Additionally there is a specific exclusion for confinement, treatment, or service for cosmetic surgery, unless the surgery results from an accidental injury and is performed not more than 12 months after the date of that injury.

Under "Eligible Expenses" page 15 of the CeltiCare policy and page 16 of the Celtic Basic policy reflect:

SECTION IV – BENEFITS

Your Benefits

- **CLEFT LIP AND CLEFT PALATE** for newborn children born with cleft lip or cleft palate or both, care and treatment shall include, to the extent *medically necessary:* 1) oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; 2) prosthetic treatment such as obturators, speech appliances and feeding appliances; 3) orthodontic treatment; 4) prosthodontic treatment; 5) habilitative speech therapy; 6) otolaryngology treatment; 7) audiological assessments and treatment.

Page 15 of the Standard PPO policy reflects:

Category B includes:

(i) Dental Services to repair damage to the jaw and sound natural teeth, if the

damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident, or treatment of cleft lip or cleft palate;

Page 22 of the Standard PPO policy reflects:

Limitations

Covered Charges will not include and no benefits will be paid for:

f. confinement, treatment, or service for Cosmetic Surgery, unless the surgery results from an accidental injury and is performed not more than 12 months after the day of that injury.

Page 13 of the Standard Indemnity policy reflects:

SECTION B – COMPREHENSIVE MEDICAL

Covered Charges

j. Dental services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident;

Page 21 of the Standard Indemnity policy reflects:

Limitations

Covered Charges will not include and no benefits will be paid for:

f. confinement, treatment, or service for Cosmetic Surgery, unless the surgery results from an accidental injury and is performed not more than 12 months after the day of that injury;

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy
I5-716-00073B	Colorado Mandated Individual Conversion Policy Standard PPO Plan
I5-714-00072	Colorado Mandated Individual Conversion Policy Standard Indemnity Plan

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to accurately reflect the mandated coverage to be provided for the care and treatment of children born with cleft lip, cleft palate or both as required by Colorado insurance law.

Issue E15: Failure to reflect correct or complete information on certificates of creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. … [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days.* For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days. [Emphasis added.]

Section 5. Rules

A. <u>Application of federal laws concerning creditable coverage.</u>

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. *Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail*. [Emphasis added.]

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, *if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations*. [Emphasis added.]

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45C.F. R. 146.115(a)(3), or 45C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation*. [Emphasis added.]

The Certificate of Creditable Coverage Form used by the Company during 2005 reflects an incorrect number of sixty-three (63) instead of ninety (90) days to be allowed for a break in coverage for the purpose of giving credit for previous creditable coverage. Colorado law prevails over the federal regulations and indicates creditable coverage may be credited and certified if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Additionally the Form does not reflect the definition of "significant break in coverage" required by Colorado insurance law.

The Certification of Individual Health Insurance Coverage being used by the Company reflects the following on page 1:

All individuals identified on this certification have had at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break).

Form Number	Form Name
None	Certification Of Individual Health Insurance Coverage

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of creditable coverage to reflect correct and complete information as required by Colorado insurance law.

Issue E16: Failure to use one of the three required Basic health benefit plan design options as conversion coverage.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 4. Rules

A. 1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., *and as conversion coverage pursuant to §10-16-108, C.R.S.* However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan *or to those individuals purchasing a basic conversion plan*. [Emphases added.]

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier *shall title* and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) *(Basic Health Benefit Plan without Specified Mandates, Basic High Deductible Health Benefit Plan or Basic High Deductible Health Benefit Plan without Specified Mandates)*] for Colorado". [Emphases added.]

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
November 1, 2004

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled *"Basic Health Benefit Plan without Specified Mandates", Basic High Deductible Health Benefit Plan", or "Basic High Deductible Health Benefit Plan without Specified Mandates"*. [Emphasis added.]

5. All basic and standard health benefit plans shall also comply with the following requirements:

B. Benefit Modifications: The form and level of coverages specified in the

> tables labeled "Basic Health Benefit Plan without Specified Mandates", "Basic High Deductible Health Benefit Plan", "Basic High Deductible Health Benefit Plan", "Basic High Deductible Health Benefit Plan without Specified Mandates" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

Celtic Insurance Company issues Conversion Policies in connection with its Conversion Program, which is made available to other insurance carriers, self-funded employer groups and HMO's who enter into an agreement with Celtic to provide conversion coverage to certain eligible individuals whose group coverage has terminated. A Celtic Conversion Policy is issued in lieu of a plan offered by the original carrier, self-funded employer group and/or HMO. The following carriers, that have Colorado members, currently have conversion agreements in place with Celtic: Zurich Life of North America (HMO), Union Labor Life, PacifiCare Life & Health, Fidelity Security Life, American Fidelity Assurance, Medica Insurance, and Guarantee Trust Life. Celtic issued two Colorado conversion policies in 2005, one of these has lapsed and the other one remains in force.

The Company is not using one of the three basic plan design options required for use as conversion coverage in Colorado. Only two (2) plans were provided for review and the titles of these plans are: Colorado Basic Plan and Colorado Basic PPO Plan. The plans both have the mandated benefits that are not to be included in the "Basic Health Benefit Plan without Specified Mandates" and the "Basic High Deductible Health Benefit Plan without Specified Mandates". The deductibles reflected in these two (2) conversion plans are not the deductibles required for the remaining option of a "Basic High Deductible Health Benefit Plan". It appears the plans being used were those required prior to the newly enacted statutory provision, effective July 1, 2004, that required use of one of three basic plan design options for conversion coverage.

Form Number	Form Name
I5-713-00071	Colorado Mandated Individual Conversion Plan Colorado Basic Plan
I5-715-00073A	Colorado Mandated Individual Conversion Plan Colorado Basic PPO Plan

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its conversion plan includes one or more of the three Basic health benefit plan design options required by Colorado insurance law.

Issue E17: Failure to include accurate benefits and coverage wording in the Standard PPO health benefit policy.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, *medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription*. [Emphasis added.]

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

(C) As used in this subparagraph (III), "medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved

pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

(5) Mental illness

(a) … For the purpose of this subsection (5), "partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period. [Emphasis added.]

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14) of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or
(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or The child has sustained extensive orofacial and dental trauma.
(IV) The child has sustained extensive orofacial and dental trauma.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this

subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

Section 10-16-704, C.R.S., Network adequacy, states:

(2)(a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise *and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers*. [Emphasis added.]

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states:

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) A provision that clearly states that *the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*; [Emphasis added.]

Colorado Insurance Regulation 4-2-5, Hospital Definition, promulgated under the authority of § 10-1-109, C.R.S., states:

Section 4. Definitions

"Hospital" means a hospital currently licensed or certified by the department of public health and environment pursuant to the department's authority under section 25-1-107(1)(l). …

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 4. Rules

A. 2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and *for use as conversion coverage pursuant to §10-16-108, C.R.S.* [Emphasis added.]

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
November 1, 2004

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

5. All basic and standard health benefit plans shall also comply with the following requirements:

   A. Balance Billing: In-network preferred provider and HMO providers are prohibited from balance billing individuals insured under the basic or standard health benefit plan. "Balance billing" refers to the practice whereby a provider bills an individual covered under the basic or standard health benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the services delivered.

   In the case of indemnity plans and out-of-network preferred provider plan benefits, carriers must alert those covered under the basic and standard health benefit plans to the fact that their provider is not prohibited from balance billing except as proscribed in §10-16-704, C.R.S. Consumers should be encouraged to discuss the issue with their provider.

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Health Benefit Plan without Specified Mandates", "Basic High Deductible Health Benefit Plan", "Basic High Deductible Health Benefit Plan without Specified Mandates" and *"Standard Health Benefit Plan" may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

Benefit Grid:

2004 COLORADO STANDARD HEALTH BENEFIT PLANS:INDEMNITY, PPO
Name of Plan

PART B: SUMMARY OF BENEFITS
(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

STANDARD PREFERRED
PROVIDER PLAN

	IN-NETWORK	OUT-OF-NETWORK[2]
4. ANNUAL DEDUCTIBLE		
a) Individual	$ 1,000	$ 2,000
b) Family	$ 2,000	$ 4,000 (Deductibles are separate from in-network deductibles)

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM		
a) Individual	$2,000 excluding flat dollar co-pays	$4,000
b) Family	$ 4,000 excluding flat dollar co-pays	$8,000
	IN-NETWORK	OUT-OF-NETWORK [2]
5A. COINSURANCE (amount paid by carrier) or COPAY (amount paid by insured/member		
a) Individual	80% coinsurance	60% coinsurance
b) Family	80% coinsurance	60% coinsurance
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2 million	

	IN-NETWORK	OUT-OF-NETWORK
8. ROUTINE MEDICAL OFFICE		

VISITS [5] PCP Specialist	 $20 copay/visit $35 copay/visit	 60% coinsurance 60% coinsurance

	IN-NETWORK	OUT-OF-NETWORK[2]
10. MATERNITY [7]	80% coinsurance (1PCP copay then deductible and coinsurance for all other charges)	60% coinsurance

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS [9] Level of coverage & restrictions on prescriptions.	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]

	IN-NETWORK	OUT-OF-NETWORK[2]
12. INPATIENT HOSPITAL	80% coinsurance	60% coinsurance

	IN-NETWORK	OUT-OF-NETWORK
13. OUTPATIENT/ AMBULATORY SURGERY	80% coinsurance	60% coinsurance

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTICS[11] a) Laboratory & X-ray b) MRI, Nuclear Medicine and Other High Tech Services	 80% coinsurance If services are delivered as part of an office visit the designated primary care provider, no additional copay or coinsurance requirement for lab & x-ray services applies. 80%	 60%

15. EMERGENCY CARE [12, 13]	$75 copay then plan pays 80% coinsurance

19. OTHER MENTAL HEALTH CARE [17]	
a) Inpatient care [16]	50% coinsurance Maximum 45 inpatient or 90 partial days/year
b) Outpatient care	50% coinsurance Plan/insurer pays maximum $1,500/year

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	80% coinsurance **(Limited to 25 total visits/year combined in and out-network)**	60% coinsurance **(Limited to 25 total visits/year combined in and out-network)**

22. DURABLE MEDICAL EQUIPMENT [21]	80% coinsurance 60% coinsurance $2,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)

24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk state II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.	
	IN-NETWORK	OUT-OF-NETWORK[2]
	80% coinsurance	60% coinsurance

28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident.

	IN-NETWORK **OUT-OF-NETWORK**
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.

Attachment 1

Covered Preventive Services [1]	
All Persons	1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer. *Chicken pox vaccination for all persons who have not had chicken pox.* [Emphasis added.]

Age 13 – 18	1 age appropriate health maintenance visit [3] every year 1 Td *Females: screening pap smears not to exceed 1 per year* [Emphasis added.] 1 hepatitis B vaccination if not given previously

Age 19 – 39	1 Td every ten years 1 age appropriate health maintenance visit every three years 1 fasting lipid panel Females ages 35-39: 1 baseline screening mammogram *and clinical breast exam* Females: screening pap smears *not to exceed 1 per year* [Emphases added.]
Age 40 – 64	1 Td every ten years 1 fasting lipid panel every five years *Either annual fecal occult blood testing or* 2 colorectal visualizations between ages 50 and 75 1 age appropriate health maintenance visit *every 24 months* Females ages 40-49: 1 screening mammogram *and clinical breast exam every 2 years (annually, if high risk*) Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months Females: *screening pap smears not to exceed 1 per year Males: Prostate screening as specified in state law* [Emphases added.]

Age 65 and older	1 influenza immunization every year 1 pneumococcal vaccine at or after age 65 *Females: screening pap smears not to exceed 1 per year* 1 Td every ten years 1 age appropriate health maintenance visit every year Females age 65 to 74: 1 screening mammogram *and clinical breast exam every 12 months* *Either annual fecal occult blood testing or* 2 colorectal visualizations between ages 50 and 75 *Males: Prostate screening as specified in state law* [Emphases added.]

Colorado Insurance Regulation 5-2-11, Transition From No-Fault Auto To Tort System, promulgated pursuant to §§ 10-1-109, and 10-4-601.5 (as codified in HB 03-1188 effective July 1, 2003), states:

> Section 5 Rules
>
> A. By operation of law, Colorado will revert from a no-fault auto system to a tort system effective on July 1, 2003. The change will occur after midnight at 12:00.01 am United States mountain time, July 1, 2003, as calculated under § 2-4-109, C.R.S.
>
> B. All auto policies issued, written or delivered on or after July 1, 2003 must be issued, written or delivered as tort policies.

The Colorado Standard PPO Plan used by the Company in its "Conversion Program" does not appear to be complete or correct in the following ways:

<u>Incomplete</u>

- There is no notification to alert covered persons that when using out-of-network preferred providers that their provider is not prohibited from balance billing.

The Company has not included any of the footnote, (superscript), numbers for the additional information concerning requirements and benefits in the Standard PPO Plan. Some of the information has been incorporated into the language of the plan, but the following footnotes reflect information that should have been included but does not appear to have been:

- Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply **ONLY IF** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

- "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. *Copays for prescription drugs,*

however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only. [Emphasis added.]

- Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

- Well-baby care includes an in-hospital newborn pediatric visit *and newborn hearing screening*. [Emphasis added.]

- Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, § 10-16-104(4), C.R.S.

- "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

- Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

- Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

- "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. *Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits*. [Emphasis added.]

- Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age.

- Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. *DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is* ***not*** *covered.* [Emphasis added.]

- Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Regulation 4-2-8.

- Although the services for laboratory & X-ray, MRI, Nuclear Medicine and Other High Tech Services are reflected as covered in various parts of the plan, it does not appear that the information regarding no additional copay or coinsurance requirement for lab and x-ray services apply if these are delivered as part of an office visit.

- There does not appear to be anything reflected concerning the physical, occupational & speech therapy that is to be provided in the plan benefits and limited to 25 total annual visits for both in and out-of-network other than when a recipient of home health care or hospice care

- The preventive care benefit of 1 smoking cessation education program does not reflect that this is a program benefit under physician supervision or as authorized by the plan.

- The preventive care services for females, does not reflect: An age group of 13 – 18 during which screening pap smears, not to exceed 1 per year, are to be provided.

- The preventive care services for females, does not reflect that a clinical breast exam is a service to be included with the baseline screening mammogram benefit. This failure to reflect applies to all age groups requiring this which are as follows: Age 35-39, Age 40-49, Age 50-64, and Age 65-74.

- The preventive care service benefit required for the following age groups, does not reflect the choice of annual fecal occult blood testing in lieu of 2 colorectal visualizations: Age 40-64 and Age 65 and older.

- Nothing is reflected concerning the preventive care service benefit of prostate screening for males which is required for the following age groups: Age 40-64 and Age 65 and older.

- Nothing is reflected to indicate under what circumstances (if high risk) females in age group 40-49 can receive a screening mammogram and clinical breast exam every year.

- The preventive care benefit of 1 screening pap smear per year for females age 65 and older is not reflected.

- The policy does not reflect the newborn hearing screening that is to be provided as part of the well-baby care under Footnote [7] for Maternity coverage.

- The list of covered Organ Transplants is incomplete as it does not reflect: heart/lung, lung, kidney/pancreas, bone marrow for Hodgkin's, neuroblastoma, lymphoma, and high

risk stage II and III breast cancer. Additionally it is not stated that peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. The limitation section of the policy uses the same incomplete list of organ transplants as the only ones for which confinement, treatment or service will be provided.

- There is nothing reflected concerning the coverage for inherited enzymatic disorders caused by single gene defects that is to be covered and additionally there is a limitation expressed in the policy that would exclude the medical foods necessary for treatment of this disorder.

- There is nothing reflected concerning the coverage to be provided for hospitalization and general anesthesia for dental procedures for dependent children when one or more of four (4) specific criteria are satisfied in the treating dentist's opinion.

- The policy does not reflect the $75 copay that is applicable for emergency care prior to the plan paying 80% coinsurance.

- The definition of a Pre-existing Condition does not appear to be complete as it does not mention the exceptions for who it would not apply.

Incorrect

- Incorrect annual deductible amounts are reflected for both the Individual and the Family and there appear to be conflicting amounts stated within the policy. If the calendar year deductibles are totaled under the Benefits Payable section they are $900 for Preferred Providers and $1,800 for Other Than Preferred Providers. The deductible amounts are all identified with an asterisk for which the only explanation is given on the next page and indicates these are maximum deductibles for Mental or Nervous Disorders and Alcoholism and Substance Abuse.

- An incorrect Lifetime or Benefit Maximum to be paid by the plan for all care is reflected as $1,000,000. The correct amount is $2 million.

- Incorrect Out-Of-Pocket Annual Maximum amounts are reflected as follows:

Preferred Providers:	Individual-$1,500. This should be $2,000
	Family-$3,300. This should be $4,000
Out-Of-Network:	Individual-$5,600. This should be $4,000
	Family-$11,800. This should be $8,000

- Incorrect coinsurance percentages and benefits are reflected for the following services:

  Category B - - Inpatient and Outpatient Hospital Services, Physician Hospital Services. For Other Than Preferred Providers an incorrect percentage of 50% is reflected. This should be 60%. Additionally, the services at a physician's office or

clinic should be separated under the heading of "Routine Medical Office Visits" with the following copay amounts instead of a coinsurance percentage: PCP-$20 copay/visit and Specialist-$35 copay/visit.

Category C - - Durable Medical Equipment and Outpatient Prescription Drugs. An incorrect percentage of 50% is reflected. This should be 80% for durable medical equipment for both preferred providers and other than preferred providers. The following copay amounts should be reflected for prescription drugs, for both in and out-of-network, rather than a coinsurance percentage: $10 copay preferred generic; $30 copay preferred brand name and $50 copay non-preferred.

Category D - - This category reflects an incorrect coinsurance percentage of 50% for Other Than Preferred Preventive Care. This should be 60%. This benefit should be separated into categories of 1) Children's services (no deductible) and 2) Adults' services. The $10 per visit that is reflected should be $20 copay/visit.

The annual maximum amount allowed for Durable Medical Equipment is incorrectly reflected as $800 and should be $2,000.

- An incorrect maximum annual amount of $1,000 is reflected for Outpatient Care under "Other Mental Health Care". This maximum annual amount should be $1,500.

- The covered charges for other care delivered in a hospital emergency room is more limiting than allowed by Colorado insurance law as in addition to being authorized by the Company, this care is allowed if the covered person was referred by his/her primary care physician.

- The Covered Preventive Services for all persons does not reflect the following benefit: "Chicken pox vaccination for all persons who have not had chicken pox."

- The preventive care services age category of 13 – 24 months is incorrect for 2 well child visits. This would leave a child without any well child visits for a year as the next age category is 3 – 6 years. The correct age category that should be reflected is 13- 35 months.

- The preventive care services, for the following age groups for females reflects an incorrect number of pap smears (1 every three calendar years) to be provided: Ages 19 – 39, Ages 40-49 and Ages 50 - 64. The requirement is that pap smears not exceed 1 per year.

- The policy reflects the following preventive care restriction regarding pap smears, for all female age groups,: "excluding women who have had a hysterectomy". There is no provision in Colorado insurance law for this restriction.

- The age group of 40 - 64 reflects an incorrect preventive care benefit of 1 age appropriate health maintenance visit ever calendar year. Colorado insurance law

provides for one of these types of visits every 24 months.

- The three age groups reflecting the preventive care benefit for colorectal visualizations incorrectly indicates between ages 50 and 70. This should be between ages 50 and 75.

- The policy incorrectly indicates that the deductible does not apply to pre-natal care. In-network services are subject to an 80% coinsurance, one (1) PCP copay, then the deductible and coinsurance for all other charges applies. The out-of-network coinsurance percentage is 60%.

- A copay amount is incorrectly reflected for a well baby newborn pediatric examination. The language also indicates there is a choice between the copay and use of an incorrect coinsurance percentage of 50%. This newborn pediatric examination and newborn hearing screening should be covered the same as all other inpatient hospital services at the correct coinsurance percentage of 80% for in-network and 60% for out-of-network.

- The policy incorrectly indicates that outpatient prescriptions for obstetrical care and family planning are payable as other outpatient prescription drugs at 50% of covered charges. For both in and out-of-network, prescription drugs are paid on a copay basis depending on whether the drugs are 1) preferred generic, 2) preferred brand name, or 3) non-preferred.

- The policy reflects an incorrect coinsurance percentage of 50% for organ transplants using an out-of-network provider. These services should be covered with 60% coinsurance.

- The policy reflects a limitation that would not allow the mandated hospitalization and general anesthesia for dental procedures for dependent children if certain criteria are met in the treating dentist's opinion.

- The definition of a "hospital" appears to be more restrictive than the definition of a "hospital" that is required by Colorado insurance law. There is no requirement that a hospital be recognized as a hospital by the Joint Commission on Accreditation of Hospitals which awards accreditation, if warranted, after an evaluation of a hospital's systems and processes.

- The policy reflects that it is the insured person's responsibility to initiate the certification process used by the Company to determine preauthorization for particular services, treatments or procedures. Colorado insurance law requires this to be the sole responsibility of the participating provider ordering the services, treatments or procedures.

- The policy reflects that benefits under the plan will be coordinated with coverage required under the Colorado Auto Accident Reparations Act (No-Fault). Colorado's No-Fault Act was repealed effective July 1, 2003, making it a Fault or "tort" state. On or after July 1, 2003 the law required

any newly written business to be "tort" and any policies that renewed on or after this date were to be converted to "tort".

- The policy's definition of "Deductible" reflects an incorrect statement concerning the maximum deductible for a family. The correct maximum deductible for a family is twice an insured person's deductible not three times the insured person's deductible for both in and out-of-network.

- The policy reflects a definition of "Dental Services" that is not in compliance with the fact that dental care is not covered except for dental care needed as a result of an accident. Additionally, this definition is in conflict with the limitations section of the policy which reflects coverage for dental services only as described under the Covered Charges section of the plan. Covered Charges indicates dental services are covered if, 1) they are the direct result of an accident or 2) for treatment of cleft lip or cleft palate.

- The policy reflects that even if an insured has not enrolled for Medicare, the amount that Medicare would have paid is subtracted from the plan's benefits. This is more limiting than allowed by Colorado insurance law. There would have to be other valid insurance to coordinate benefits.

- The policy definitions of a Medical Emergency, Emergency Care and Emergency Condition are more limiting than allowed by Colorado insurance law.

- The policy reflects a definition of Partial Hospitalization that is not in compliance with Colorado insurance law and is in conflict with the description of benefits provided elsewhere in the policy. The definition incorrectly states that partial confinement in a hospital consists of not more than 14 hours in any 24 hour period. The description of benefits correctly states that partial confinement in a hospital consists of not more than 12 hours in a 24 hour period.

- The policy indicates that if the Company or the Preferred Provider Organization terminates the arrangement, Celtic will only pay the level of benefits as described in the policy for medical care received from "Other Than Preferred Providers". This is not in compliance with Colorado insurance law that requires a carrier that has no participating providers to arrange for a referral to a provider with the necessary expertise and to ensure that the covered person obtains the covered benefit at no greater cost than if the benefit were obtained from a participating provider.

Page 1 of the policy reflects:

BENEFITS

MAJOR MEDICAL EXPENSE PLAN: 300SP

Deductible (Annual):	$300
Family Maximum Deductible:	$900
Lifetime Maximum Benefit:	$1,000,000

Page 5 of the policy reflects:

Scheduled Benefits

Comprehensive Medical

Durable Medical Equipment ----------50% up to $800/Year or lesser of purchase Charge

Overall Lifetime Maximum Payment Limit

The Comprehensive Medical Lifetime Maximum Payment Limit for each person during his or her lifetime for all causes is $1,000,000.

Page 6 of the policy reflects:

Medical Care Categories of Covered Charges

Comprehensive Medical benefits payable will be based on four Categories of medical care services identified as Categories A, B, C and D. SEE PART III, SECTION B, FOR A FULL DESCRIPTION OF COVERED CHARGES INCLUDED UNDER EACH CATEGORY.

Benefits Payable

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician or other provider who has contracted with the Preferred Provider Organization network (see below).

SERVICE	PREFERRED PROVIDERS	OTHER THAN PREFERRED PROVIDERS
Category A- -Services to treat an Emergency Condition in a Hospital Emergency Room and use of an Ambulance	80%	80%
Deductible Required	$300*	$600*
Category B- -Inpatient and outpatient Hospital Services, Physician Hospital Services, Services at home or at a Physician's office or clinic and other services shown in Part III, Description of Benefits	80%	50%

Deductible Required	$300*	$600*
Category C- -Durable Medical Equipment and Outpatient Prescription Drugs	50%	50%
Deductible Required	$300*	$600*
Category D- -Preventive Care	$10 per visit	
Deductible Required	NO DEDUCTIBLE	NO DEDUCTIBLE

Page 7 of the policy reflects:

Deductible Amounts

*You pay a single $300 per individual deductible each calendar year (or $900 family deductible, but not counting more than $300 for any one person) for services from Preferred Providers, or a single $600 per individual deductible each calendar year (or $1,800 family deductible, but not counting more than $600 for any one person) for services from Other Than Preferred Providers. Covered Charges used to satisfy the individual calendar year deductible that apply when care is received Preferred Providers will not be counted toward satisfaction of the individual maximum calendar year deductible when care is received from Other Than Preferred Providers. The deductible does not apply to pre-natal care.

Page 8 of the policy reflects:

Out-of-Pocket Expense Maximum Per Calendar Year

	PREFERRED PROVIDERS	OTHER THAN PREFERRED PROVIDERS
INDIVIDUAL	$1,500	$5,600
FAMILY	$3,300	$11,800

Pages 14 and 16 of the policy reflect:

SECTION B – COMPREHESIVE MEDICAL

Covered Charges

Covered Charges will be the actual cost charges to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Maximum Allowable Fees.

Covered Charges will be based on four Categories of medical care services as described below.

Category C includes:

(b) The lesser of the rental or purchase of medically necessary durable medical equipment up to a maximum benefit of $800 for each Insured Person each calendar year.

Page 13 of the policy reflects:

> **OUTPATIENT SERVICES CENTER**
>
> If you or one of your Dependents receives treatment of service on an outpatient basis due to a mental or nervous disorder, benefits will be payable for Covered Charges incurred for such treatment or service.
>
> Benefits will be payable at 50% to a maximum benefit of $1,000 for each Insured Person each calendar year.

Page 15 of the policy reflects:

> **Category A** includes the services to treat an Emergency Condition:
>
> (a) Care and treatment, including a physician's services, in a Hospital Emergency Room to treat an Emergency condition;
> (b) Charges for transportation by an ambulance provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) for treatment of an Emergency Condition; and *For all other care delivered in a Hospital Emergency Room* or transportation in an ambulance service no benefit will be payable unless care within a Hospital Emergency Room or transportation in an ambulance service *was authorized by the Celtic Insurance Company*. [Emphases added.]

Pages 15 and 16 under Covered Charges reflects:

> **Category B** includes:
>
> (i) Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident, or treatment of cleft lip or cleft palate;

Page 22 of the policy reflects:

> **Limitations**
>
> Covered Charges will not include and no benefits will be paid for:
>
> d. Dental Services or materials, except as described under Covered Charges; …

Page 25 of the policy under "The Health Care Certification Program" reflects:

> **Notification**

It is the insured person's responsibility to initiate the certification process and arrange for his/her physician's cooperation in releasing necessary medical information. The insured person may also arrange for his/her physician to initiate the process, however, if for any reason the insured's physician or the hospital fails to cooperate, the penalty still applies.

Pages 27 and 28 of the policy reflect:

SECTION C – PRE-EXISTING CONDITIONS RESTRICTIONS

A Pre-existing Condition is a sickness or injury for which a person was confined or received treatment or service in the six month period before becoming insured for Comprehensive Medical Expense Coverage.

No benefits will be payable for a Pre-existing Condition until that person has been insured for Comprehensive Medical Expense Insurance for six consecutive months and then benefits will be payable only with respect to days of confinement occurring after that date or to treatment or service received after that date.

In determining whether the Pre-existing Condition Restriction applies to a person, credit will be given for his or her satisfaction or partial satisfaction of a similar provision under a Qualifying Previous Coverage, provided the Qualifying Previous Coverage was continuous to a date not more than 90 days prior to the effective date of the person's insurance under this plan, exclusive of any applicable eligibility waiting period under this plan.

Page 29 of the policy reflects:

No-Fault Auto Coordination

Benefits under this Plan will be coordinated with the applicable minimum coverage's required under the Colorado Auto Accident Reparations Act (No-Fault), Colorado Revised Statutes 1973, as amended.

Page 33 of the policy reflects:

When Medicare Pays First

Even if a person has not enrolled for Medicare Parts A and B, the amount that Medicare would have paid is subtracted from Plan benefits.

Page 36 of the policy under **PART IX - DEFINITIONS** reflects:

Deductible

The amount of incurred covered charge that must be paid by or on behalf of the insured person per calendar year before we pay benefits. The maximum deductible for a family is [three] times an insured person's deductible. The deductible is shown on the Schedule of Benefits.

Page 37 of the policy under **PART IX - DEFINITIONS** reflects:

Dental Services

Means any confinement, treatment or service, provided to diagnose, prevent or correct:

(1) periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth);
(2) malocclusion (abnormal positioning and/or relationship of the teeth); and/or
(3) ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening). However, the term Dental Services will include treatment performed to replace or restore any natural teeth in connection with the use of any such appliance.

Page 38 of the policy under **PART IX - DEFINITIONS** reflects:

Emergency Care

Means care for a life or limb threatening incident.

Emergency Condition

Emergency Condition means sudden, unexpected serious onset of illness or accidental bodily injury subject to the following initial requirements:

(1) the condition so treated must have required treatment of such immediate nature that the patient's life or limbs would have been jeopardized had the patient been taken to a treatment location where the services of his/her Personal Physician would be available:

(2) the patient, if an adult, must have been in shock or have been unconscious or otherwise incapable of rational independent judgment concerning the medical treatment or services rendered; or

(3) the patient, if a minor, must have been without the presence of an adult member of the patient's family or legal guardian.

Page 42 of the policy under **PART IX - DEFINITIONS** reflects:

Medical Emergency

Means the sudden onset of severe medical symptoms that:

(1) could not have been reasonably anticipated; and

(2) require immediate medical treatment.

Page 44 of the policy under **PART IX - DEFINITIONS** reflects:

Partial Hospitalization

Means continuous treatment (consisting of not less than three hours and not more than 14 hours in any 24 hour period) under a program based in a Hospital.

Page 45 of the policy under **Preferred Provider** reflects:

Celtic has the right to terminate the Preferred Provider Organization (PPO) portion of this plan if Celtic or the Preferred Provider Organization (PPO) terminates the arrangement. *In the event of termination, Celtic will pay the level of benefits as described in this policy for medical care received from "Other Than Preferred Providers*". [Emphasis added.] In addition, Celtic will assume responsibility for assisting the insured person with the Certification requirements described in PART II, Section B of this plan under the Health Care Certification Program provision.

Page 16 of the policy reflects:

Category D includes:

(a) the following preventive care services:

Ages 13 – 24 months	2 Well child visits
Ages 3 – 6 years	3 Well child visits
All Persons	1 smoking cessation education program benefit per lifetime, not to exceed $150 payment by the Company

Page 17 of the policy reflects:

Ages 40-64	2 colorectal visualizations between ages 50 and 70 1 age appropriate health maintenance visit every calendar year
Ages 65 and older	2 colorectal visualizations between ages 50 and 70

Page 17 of the policy reflects:

Females:

Ages 19 – 39	1 pap smear every three calendar years, (excluding women who have had a hysterectomy)
Ages 35-39	1 screening mammogram
Ages 40-49	1 pap smear every three calendar years, (excluding women who have had a hysterectomy) 1 screening mammogram every one to two calendar years
Ages 50-64	1 pap smear every three calendar years, (excluding women who have had a hysterectomy) 1 screening mammogram every calendar year 2 colorectal visualizations between ages 50 and 70

Pages 14 and 15 of the policy reflect:

Covered Charges

Covered Charges will be based on four Categories of medical care services as described below.

Category B includes:

(i) Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident, or treatment of cleft lip or cleft palate;

Page 21 of the policy reflects:

Obstetrical Care and Family Planning

Covered Charges will include charges for Obstetrical Care and Family Planning including the following:

a. Benefits for pre-natal care. The deductible does not apply to pre-natal care.

c. Benefits for Hospital care of a newborn child shall be considered a Covered Charge. The Hospital deductible described in the second Provision of this Section, will not apply for a newborn child if he/she is discharged with the mother, if the mother is covered under this plan as an Insured Person. However, any applicable Hospital deductible will apply if the newborn remains

hospitalized or is hospitalized after the mother's discharge, or if the mother is not covered under this plan. A newborn shall also be eligible for a well baby newborn pediatric examination subject to the $10.00 co-pay or 50% payable described under "Preventive Care" in Category D, in this Section.

e. Benefits for Family Planning counseling, information on birth control, and insertion of contraceptive devices or fitting of diaphragms. The benefit payable for outpatient prescription contraceptives shall be payable as other outpatient prescription drugs at 50% of the Covered Charges, as described in this Section.

g. Benefits for treatment and screening for sexually transmitted diseases shall be considered Covered Charges, except that outpatient prescription are payable at 50% of Covered Charges as described in this Section.

Pages 21 and 22 of the policy reflect:

Organ Transplants

Covered Charges will include charges for the following human-to-human Organ Transplants:

- heart;
- liver;
- kidney;
- cornea; and
- bone marrow for: aplastic anemia, leukemia, immunodeficiency disease, and Wiskott-Aldrich syndrome.

Use of Celtic's Transplant Network Provider for the (sic) these Non-Experimental and Non-Investigational transplant procedures as defined by the Transplant Network Provider are payable at 80% of Covered Charges. If you choose to use the services of a provider other than Celtic's Transplant Network Provider for these Non-Experimental and Non-Investigational transplant procedures as defined by the Transplant Network Provider, Covered Charges are payable *at 50%.* [Emphasis added.]

Page 22 of the policy reflects:

Limitations

Covered Charges will not include and no benefits will be paid for:

d. *Dental Services or materials, except as described under Covered Charges*; eye examination for the correction of vision or the fitting of glasses, vision materials (frames or lenses), hearing aids, drugs or medicines that do not require a Physician's prescription, vitamins, minerals, nutritional supplements or *special diets (whether they require a Physician's prescription or not)*, comfort or convenience services and supplies; [Emphases added.]

Page 23 of the policy reflects:

Limitations

Covered Charges will not include and no benefits will be paid for:

l. human-to-human organ transplants except for confinement, treatment, service and materials related to the following human-to-human organ or tissue transplant procedures (including charges for organ or tissue procurement):

- heart,
- liver,
- kidney,
- cornea, and
- bone marrow for: aplastic anemia, leukemia, immunodeficiency disease and Wiskott-Aldrich syndrome;

Form Number	Form Name
I5-716-00073B	Colorado Mandated Individual Conversion Plan Standard PPO Plan

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-104, 10-16-108, C.R.S. and Colorado Insurance Regulations 4-2-5, 4-6-5, and 5-2-11. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its Standard PPO health benefit plans reflect complete and accurate benefits and coverage wording as required by Colorado insurance law.

Issue E18: Failure to include accurate benefits and coverage wording in the Standard indemnity health benefit policy.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, *medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription*. [Emphasis added.]

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

(C) As used in this subparagraph (III), "medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

(13) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental general anesthesia when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14) of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or
(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or The child has sustained extensive orofacial and dental trauma.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(5) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

Section 10-16-704, C.R.S., Network adequacy, states:

(2)(a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise *and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers*. [Emphasis added.]

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states:

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) A provision that clearly states that *the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*; [Emphasis added.]

Colorado Insurance Regulation 4-2-5, promulgated under the authority of § 10-1-109, C.R.S., states:

Section 4. Definitions

"Hospital" means a hospital currently licensed or certified by the department of public health and environment pursuant to the department's authority under section 25-1-107 (1)(l). …

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 4. Rules

A. 2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and *for use as conversion coverage pursuant to §10-16-108, C.R.S.* [Emphasis added.]

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
November 1, 2004

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

5. All basic and standard health benefit plans shall also comply with the following requirements:

   A. Balance Billing: In-network preferred provider and HMO providers are prohibited from balance billing individuals insured under the basic or standard health benefit plan. "Balance billing" refers to the practice whereby a provider bills an individual covered under the basic or standard health benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the services delivered.

      In the case of indemnity plans and out-of-network preferred provider plan benefits, carriers must alert those covered under the basic and standard health benefit plans to the fact that their provider is not prohibited from balance billing except as proscribed in §10-16-704, C.R.S. Consumers should be encouraged to discuss the issue with their provider.

   B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Health Benefit Plan without Specified Mandates", "Basic High Deductible Health Benefit Plan", "Basic High Deductible Health Benefit Plan without Specified Mandates" and "*Standard Health Benefit Plan" may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

Benefit Grid:

2004 COLORADO STANDARD HEALTH BENEFIT PLANS:INDEMNITY, PPO
Name of Plan

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	STANDARD INDEMNITY PLAN
4. ANNUAL DEDUCTIBLE	
a) Individual	$1,000
b) Family	$3,000

5. OUT-OF-POCKET ANNUAL MAXIMUM [3]	
a)Individual	$2,000 (Includes deductible and coinsurance)
b)Family	$6,000 (Includes deductibles and coinsurance)

5A. COINSURANCE (amount paid by carrier) or COPAY (amount paid by insured/member)	
a)Individual	80% coinsurance
b)Family	80% coinsurance

8. ROUTINE MEDICAL OFFICE VISITS[5]	
PCP	80% coinsurance
SPECIALIST	80% coinsurance

9.PREVENTIVE CARE [6]	For all plans, only specified preventive services are covered.
a) Children's services (No deductible)	80% coinsurance
b) Adults' services	80% coinsurance

10. MATERNITY [7]	80% coinsurance Deductible and coinsurance apply

12. INPATIENT HOSPITAL	80% coinsurance

11. PRESCRIPTION DRUGS [9] Level of coverage & restrictions on prescriptions.	$10 copay preferred generic; $30 copay preferred brand name $50 copay non-preferred [9a]

13. OUTPATIENT/ AMBULATORY SURGERY	80% coinsurance

15. EMERGENCY CARE [12, 13]	80% coinsurance

22. DURABLE MEDICAL EQUIPMENT [21]	80% coinsurance $2,000/year maximum

24.ORGAN TRANSPLANTS [22]	Covered transplants include liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
	80% coinsurance

28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of employment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.

Attachment 1

Covered Preventive Services [1]	
All Persons	1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer. *Chicken pox vaccination for all persons who have not had chicken pox.* [Emphasis added.]

Age 13 - 18	1 age appropriate health maintenance visit [3] every year 1 Td *Females: screening pap smears not to exceed 1 per year* [Emphasis added.] 1 hepatitis B vaccination if not given previously

Age 19 - 39	1 Td every ten years 1 age appropriate health maintenance visit every three years 1 fasting lipid panel Females ages 35-39: 1 baseline screening mammogram *and clinical breast exam* Females: screening pap smears *not to exceed 1 per year* [Emphases added.]

Age 40 - 64	1 Td every ten years 1 fasting lipid panel every five years *Either annual fecal occult blood testing or* 2 colorectal visualizations between ages 50 and 75 1 age appropriate health maintenance visit *every 24 months* Females ages 40-49: 1 screening mammogram *and clinical breast exam every 2 years (annually, if high risk*) Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months Females: *screening pap smears not to exceed 1 per year Males: Prostate screening as specified in state law* [Emphases added.]

Age 65 and older	1 influenza immunization every year 1 pneumococcal vaccine at or after age 65 *Females: screening pap smears not to exceed 1 per year* 1 Td every ten years 1 age appropriate health maintenance visit every year Females age 65 to 74: 1 screening mammogram *and clinical breast exam every 12 months* *Either annual fecal occult blood testing or* 2 colorectal visualizations between ages 50 and 75 *Males: Prostate screening as specified in state law* [Emphases added.]

Colorado Insurance Regulation 5-2-11, Transition From No-Fault Auto To Tort System, promulgated pursuant to §§ 10-1-109, and 10-4-601.5 (as codified in HB 03-1188 effective July 1, 2003), states:

> Section 5 Rules
>
> C. By operation of law, Colorado will revert from a no-fault auto system to a tort system effective on July 1, 2003. The change will occur after midnight at 12:00.01 am United States mountain time, July 1, 2003, as calculated under § 2-4-109, C.R.S.
>
> D. All auto policies issued, written or delivered on or after July 1, 2003 must be issued, written or delivered as tort policies.

The Colorado Standard Indemnity Plan used by the Company in its "Conversion Program" does not appear to be complete or correct in the following ways:

Incomplete

- The title of the plan does not reflect the type of plan as being "Indemnity".

The Company has chosen not to include any of the footnote, (superscript), numbers for the additional information concerning requirements and benefits in the Standard Indemnity Plan. Some of the information has been incorporated into the language of the plan, but the following footnotes reflect information that does not appear to have been included:

- Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply *ONLY IF* plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

- "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. *Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only*. [Emphasis added.]

- Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

- Well-baby care includes an in-hospital newborn pediatric visit *and newborn hearing screening.* [Emphasis added.]

- Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, § 10-16-104(4), C.R.S.

- "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

- Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

- Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

- "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specified obsessive-compulsive disorder, and panic disorder. *Outpatient psychotherapy visits for biologically based*

mental illnesses are covered at the same level as routine medical office visits. [Emphasis added.]

- Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age.

- Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. *DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is* ***not*** *covered.* [Emphasis added.]

- Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado regulation 4-2-8.

- Although the services for laboratory & x-ray, MRI, Nuclear Medicine and Other High Tech Services are reflected as covered in various parts of the plan, it does not appear that the information regarding no additional copay or coinsurance for lab and x-ray services apply if these services are delivered as part of an office visit.

- There does not appear to be anything reflected concerning the physical, occupational & speech therapy that is to be provided in the plan benefits and limited to 25 total annual visits other than when a recipient of home health care or hospice

- The benefit of 1 smoking cessation education program does not reflect that this is a program benefit under physician supervision or as authorized by the plan.

- The preventive care services for females, does not reflect: An age group of 13 – 18 during which screening pap smears, not to exceed 1 per year, are to be provided.

- The preventive care services for females, does not reflect that a clinical breast exam is a service to be included with the baseline screening mammogram benefit. This failure to reflect applies to all age groups requiring this benefit: Age 35-39, Age 40-49, Age 50-64, and Age 65-74.

- The preventive care service benefit required for the following age groups does not reflect the choice of annual fecal occult blood testing in lieu of 2 colorectal visualizations: Age 40-64 and Age 65 and older.

- Nothing is reflected concerning the preventive care service benefit of prostate screening for males that is required for the following age groups: Age 40-64 and Age 65 and older.

- Nothing is reflected to indicate under what circumstances (if high risk) females in age group 40-49 can receive a screening mammogram and clinical breast exam every year.

- The preventive care benefit of 1 screening pap smear per year for females age 65 and older is not reflected.

- The policy does not reflect the newborn hearing screening that is to be provided as part of the well-baby care under Footnote [7] for Maternity coverage.

- The list of covered Organ Transplants is incomplete as it does not reflect: heart/lung, lung, kidney/pancreas, bone marrow for Hodgkin's, neuroblastoma, lymphoma and high risk stage II and III breast cancer. Additionally it is not stated that peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. The limitation section of the policy uses the same incomplete list of organ transplants as the only ones for which confinement, treatment or service will be provided.

- There is nothing reflected concerning the coverage for inherited enzymatic disorders caused by single gene defects that is to be covered and additionally there is a limitation expressed in the policy that would exclude the medical foods necessary for treatment of this disorder.

- There is nothing reflected concerning the coverage to be provided for hospitalization and general anesthesia for dental procedures for dependent children when one or more of four (4) specific criteria are satisfied in the treating dentist's opinion.

- The definition of a Pre-existing Condition does not appear to be complete as it does not mention the exceptions for who it would not apply.

<u>Incorrect</u>

- Incorrect annual deductible amounts for both the Individual and the Family Deductibles are reflected as follows:

Deductible (Annual):	$500.	This should be $1,000
Family Maximum Deductible:	$1,500	This should be $3,000

- An incorrect out-of-pocket annual maximum for family is reflected as $4,500 under "Benefits Payable". This should be $6,000.

- Incorrect coinsurance percentage and benefits are reflected for the following services:

  For inpatient and physician hospital services, an incorrect percentage of 70% is

reflected. This should be 80%. Additionally, the services at a physician's office or clinic should be separated under the heading of "Routine Medical Office Visits" with the following coinsurance percentage:

PCP: 80%
Specialist: 80%

- An incorrect percentage of 50% is reflected for Durable Medical Equipment and Outpatient Prescription Drugs. This should be 80% for Durable Medical Equipment. The following copay amounts should be reflected for prescription drugs rather than a coinsurance percentage: $10 copay preferred generic; $30 copay preferred brand name and $50 copay non-preferred.

- The coinsurance percentage of 80% should be reflected for both Children's and Adults' Preventive Care services rather than a copay amount of $10 per visit for Covered Charges.

- The annual maximum amount allowed for Durable Medical Equipment is incorrectly reflected as $800. This should be $2,000.

- For Outpatient/Ambulatory Surgery and Emergency Care services, an incorrect percentage of 70% is reflected. This should be 80%.

- The charges for other care delivered in a hospital emergency room is more limiting than allowed by Colorado insurance law as in addition to being authorized by the Company, this care is allowed if the covered person was referred by his/her primary care physician.

- The Covered Preventive Services for all persons does not reflect the following benefit: "Chicken pox vaccination for all persons who have not had chicken pox."

- The preventive care services age category of 13 – 24 months is incorrect for 2 Well child visits. This would leave a child without any Well child visits for a year as the next age category is 3 – 6 years. The correct age category that should be reflected is 13 – 35 months.

- The preventive care services for the following age groups for females reflects an incorrect number of pap smears (1 every three calendar years) to be provided: Ages 19 – 39, Ages 40 – 49 and Ages 50 – 64. The requirement is that pap smears not exceed 1 per year.

- The policy reflects the following preventive care restriction regarding pap smears, for all female age groups: "excluding women who have had a hysterectomy." There is no provision in Colorado insurance law for this restriction.

- The age group of 40 – 64 reflects an incorrect preventive care benefit of one age appropriate health maintenance visit ever year. Colorado insurance law provides for one of these types of visits every twenty-four (24) months.

- The three age groups reflecting the preventive care benefit for colorectal visualizations incorrectly indicates between ages 50 and 70. This should be between ages 50 and 75.

- The policy incorrectly indicates that the deductible does not apply to pre-natal care. Pre-natal and all other maternity related charges are subject to the deductible and coinsurance. The coinsurance percentage is 80%.

- A copay amount is incorrectly reflected for a well baby newborn pediatric examination. This newborn pediatric examination and newborn hearing screening should be covered the same as all other inpatient hospital services at the correct coinsurance percentage of 80%.

- The policy incorrectly indicates that outpatient prescriptions for obstetrical care and family planning are payable as other outpatient prescription drugs at 50% of covered charges. Prescription drugs are paid on a copay basis depending whether the drugs are 1) preferred generic, 2) preferred brand name, or 3) non-preferred.

- The policy reflects an incorrect coinsurance percentage of 70% for organ transplants. These services should be covered with 80% coinsurance.

- The policy reflects a limitation that would not allow the mandated hospitalization and general anesthesia for dental procedures for dependent children if certain criteria are met in the treating dentist's opinion.

- The definition of a "hospital" appears to be more restrictive than the definition of a "hospital" that is required by Colorado insurance law. There is no requirement that a hospital be recognized as a hospital by the Joint Commission on Accreditation of Hospitals which awards accreditation, if warranted, after an evaluation of a hospital's systems and processes.

- The policy reflects that it is the insured person's responsibility to initiate the certification process used by the Company to determine preauthorization for particular services, treatments or procedures. Colorado insurance law requires this to be the sole responsibility of the participating provider ordering the services, treatments or procedures.

- The policy reflects that benefits under the plan will be coordinated with coverage required under the Colorado Auto Accident Reparations Act (No-Fault). Colorado's No-Fault Act was repealed effective July 1, 2003, making it a Fault or "tort" state. On or after July 1, 2003 the law required any newly written business to be "tort" and any policies that renewed on or after this date were to be converted to "tort."

- The policy reflects a definition of "Dental Services" that is not in compliance with the fact that dental care is not covered except for dental care needed as a result of an accident. Additionally, this definition is in conflict with the limitations sections of the policy which reflects coverage for dental services only as described under the Covered Charges section of the plan. The definition of Dental Services indicates dental services

are covered for 1) periodontal disease, 2) malocclusion, and 3) ailments or defects of the teeth and supporting tissue and bone.

- The policy reflects that even if an insured has not enrolled for Medicare, the amount that Medicare would have paid is subtracted from the plan's benefits. This is more limiting than allowed by Colorado insurance law. There would have to be other valid insurance to coordinate benefits.

- The policy definition of a Medical Emergency, Emergency Care and Emergency Condition are more limiting than allowed by Colorado insurance law.

- The policy reflects a definition of Partial Hospitalization that is not in compliance with Colorado insurance law and is in conflict with the description of benefits provided elsewhere in the policy. The definition incorrectly states that partial confinement in a hospital consists of not more than 14 hours in any 24 hour period. The description of benefits correctly states that partial confinement in a hospital consists of not more than 12 hours in a 24 hour period.

Page 1 of the policy reflects:

Plan: Colorado Standard Plan

BENEFITS

MAJOR MEDICAL EXPENSE PLAN:	500SI
Deductible (Annual):	$500
Family Maximum Deductible:	$1,500

Page 9 of the policy reflects:

Deductible Amount

The individual deductible amount for you and each of your Dependents each calendar year will be:

d. $500 with respect to all other Covered Charges.

The family maximum deductible with respect to the individual calendar year deductible described above for all insured persons in the same family (you and your Dependents) each calendar year will be $1,500, but not more than $500 of such Covered Charges for any one insured person in the family.

Page 4 of the policy reflects:

PART I – SUMMARY OF BENEFITS

MEDICAL EXPENSE COVERAGE

Scheduled Benefits

Comprehensive Medical

Durable Medical Equipment …….50% up to $800/year or lesser of purchase charge

Page 5 of the policy reflects:

Benefits Payable

Comprehensive Medical benefits payable for confinement, treatment or service received each calendar year will be:

a) 70% of each person's Covered Charges in excess of the deductible amount described below until Out-of-Pocket Expenses, including the deductible are $2,000 per person or $4,500 per family (you and your Dependents); …

Except that:

c. for durable medical equipment and outpatient drugs, the benefits shall be 50% of the Covered Charges;

Page 19 of the policy reflects:

Durable Medical Equipment

Covered Charges will include the lesser of the rental or purchase of durable medical equipment with benefits payable at 50% of Covered Charges up to a maximum benefit of $800 for each insured person per calendar year.

Pages 9, 12 and 13 of the policy reflect:

The deductible does not apply to Preventive Care for you or your Dependents. You or one of your Dependents will be responsible for payment of the $10 co-payment per visit, …

SECTION B – COMPREHENSIVE MEDICAL

Payment Conditions

If you or one of your Dependents receive treatment or service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

- in excess of the deductible amount;
- at the payment(s) indicated; and
- to the Maximum Payment Limit as described in Part I, Summary of Benefits.

Covered Charges

Preventive Care

Celtic will pay benefits for Preventive Care. The listed Preventive Care Services are not subject to the deductible and coinsurance payment. Insured Persons will be subject to the $10.00 co-payment per visit which does not apply to the Out-Of-Pocket maximum.

Ages: 0-12	$10 Co-Pay/Visit of Covered Services
Ages 13+	$10 Co-Pay/Visit of Covered Services

Page 18 of the policy reflects:

Emergency Room and Ambulance Service

Covered Charges will include charges for Hospital Emergency Room and ambulance service for treatment of an Emergency Condition with the benefit payable at 70% of Covered Charges. For all other care delivered in a Hospital Emergency Room or transportation in an ambulance service *no benefit will be payable unless care within a Hospital Emergency Room or transportation in an ambulance service was authorized by US*. [Emphasis added.]

Page 19 of the policy reflects:

Outpatient Prescription Drugs

Covered Charges will include charges for outpatient prescription drugs with the benefit of 50% of Covered Charges. …

The wording on page 13 of the policy reflects:

Covered Charges

Covered Charges will be the actual cost charges to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Maximum Allowable Fees for:

j. Dental services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident;

Pages 18 and 19 of the policy reflect:

Obstetrical Care and Family Planning

Covered Charges will include charges for Obstetrical Care and family Planning including the following:

a. Benefits for pre-natal care at *70%* of Covered Charges. The deductible does not apply to pre-natal care.

b. Benefits for pre-natal care at *70%* of Covered Charges for both Normal Pregnancy and Complications of Pregnancy.

c. Benefits for Hospital care of a newborn child shall be payable at *70%* of Covered Charges. The Hospital deductible will not apply for a newborn child if he/she is discharged with the mother, if the mother is covered under this plan as an Insured Person. However, any applicable Hospital deductible will apply if the newborn remains hospitalized or is hospitalized after the mother's discharge, or if the mother is not covered under this plan. A newborn shall also be eligible for a well baby newborn pediatric examination subject to the $10.00 co-pay described under "Preventive Care."

e. Benefits for Family Planning counseling, information on birth control, and insertion of contraceptive devices or fitting of diaphragms shall be payable at *70%* of Covered Charges. The benefit payable for outpatient prescription contraceptives shall be payable as other outpatient prescription drugs and shall be payable at *50%* of the Covered Charges.

g. Benefits for treatment and screening for sexually transmitted diseases shall be payable at *70%* of the Covered Charges, except that the benefit for outpatient prescription drugs shall be payable as other outpatient prescription drugs at *50%* of Covered Charges. [Emphases added.]

Page 19 of the policy reflects:

Organ Transplants

Covered Charges will include charges for the following human-to-human Organ Transplants:

- Heart;
- Liver;
- Kidney;
- Cornea; and
- Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, and Wiskott-Aldrich syndrome

No other transplants are covered. The benefit shall be payable at *70%* of the Covered Charges. [Emphasis added.]

Page 20 of the policy reflects:

Limitations

Covered Charges will not include and no benefits will be paid for:

d. *Dental Services or materials, except as described under Covered Charges*; eye examination for the correction of vision or the fitting of glasses, vision materials (frames or lenses), hearing aids, drugs or medicines that do not require a Physician's prescription, vitamins, minerals, nutritional supplements or *special diets (whether they require a Physician's prescription or not),* comfort or convenience services and supplies; [Emphases added.]

Page 21 of the policy reflects:

Limitations

m. confinement, treatment or services for:

1. human-to-human organ transplants except for confinement, treatment, service and materials related to the following human-to-human organ or tissue transplant procedures (including charges for organ or tissue procurement):

- heart;
- liver;
- kidney;
- cornea, and
- bone marrow for: aplastic anemia, leukemia, immunodeficiency disease and Wiskott-Aldrich syndrome;

Page 23 of the policy under "The Health Care Certification Program" reflects:

Notification

It is the insured person's responsibility to initiate the certification process and arrange for his/her physician's cooperation in releasing necessary medical information. The insured person may also arrange for his/her physician to initiate the process, however, if for any reason the insured's physician or the hospital fails to cooperate, the penalty still applies.

Page 26 of the policy reflects:

SECTION C – PRE-EXISTING CONDITION RESTRICTIONS

A Pre-existing Condition is a sickness or injury for which a person was confined or received treatment or service in the six month period before becoming insured for Comprehensive Medical Expense Coverage.

No benefits will be payable for a Pre-existing Condition until that person has been insured for Comprehensive Medical Expense Insurance for six consecutive months and then benefits will be payable only with respect to days of confinement occurring after that date or to treatment or service received after that date.

In determining whether the Pre-existing Condition Restriction applies to a person, credit will be given for his or her satisfaction or partial satisfaction of a similar provision under a Qualifying Previous Coverage, provided the Qualifying Previous Coverage was continuous to a date not more than 90 days prior to the effective date of the person's insurance under this plan, exclusive of any applicable eligibility waiting period under this plan.

Page 27 of the policy reflects:

No-Fault Auto Coordination

Benefits under this Plan will be coordinated with the applicable minimum coverage's required under the Colorado Auto Accident Reparations Act (No-Fault), Colorado Revised Statutes 1973, as amended.

Page 31 of the policy reflects:

When Medicare Pays First

Even if a person has not enrolled for Medicare Parts A and B, the amount that Medicare would have paid is subtracted from Plan benefits.

The wording on page 35 under **PART IX – DEFINTIONS** reflects:

Dental Services

Means any confinement, treatment or service, provided to diagnose, prevent or correct:

(1) periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth);

(2) malocclusion (abnormal positioning and/or relationship of the teeth); and/or

(3) ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening). However, the term Dental Services will include treatment performed to replace or restore any natural teeth in connection with the use of any such appliance.

Page 36 of the policy under **PART IX – DEFINTIONS** reflects:

Emergency Care

Means care for a life or limb threatening incident.

Emergency Condition

Emergency Condition means sudden, unexpected serious onset of illness or accidental bodily injury subject to the following initial requirements:

(1) the condition so treated must have required treatment of such immediate nature that the patient's life or limbs would have been jeopardized had the patient been taken to a treatment location where the services of his/her Personal Physician would be available;

(2) the patient, if an adult, must have been in shock or have been unconscious or otherwise incapable of rational, independent judgment concerning the medical treatment or services rendered; or

(3) the patient, if a minor, must have been without the presence of an adult member of the patient's family or legal guardian.

Some examples of Emergency Conditions are severe bleeding, suspected heart attack, stroke, serious burns and serious breathing difficulties.

Page 41 of the policy under **PART IX – DEFINITIONS** reflects:

Partial Hospitalization

Means continuous treatment (consisting of not less than three hours and not more than 14 hours in any 24 hour period) under a program based in a Hospital.

Form Number	Form Name
I5-714-00072	Colorado Mandated Individual Conversion Plan Standard Indemnity Plan

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-104, 10-16-108, 10-16-704 and 10-16-705, C.R.S. and Colorado Insurance Regulations 4-2-5, 4-6-5, and 5-2-11. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its Standard indemnity health benefit plans reflect complete and accurate benefits and coverage wording as required by Colorado insurance law.

Issue E19: Failure to accurately reflect the required and optional provisions in individual sickness and accident policies.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states:

(1) Except as provided in section 10-16-204, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) A provision as follows: "Entire contract---changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(3) Provisions as follows: "Time limit on certain defenses:" (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commending after the expiration of such two-year period."

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty, or in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain, in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.")

(4)(a) A provision as follows: "Grace period: A grace period of …… (insert a number not less than "7" for weekly premium policies, "10" monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(9) A provision as follows: "Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. …

Section 10-16-203, C.R.S., Optional provisions in individual sickness and accident insurance policies, states:

(1) Except as provided in section 10-16-204, no individual sickness and accident insurance policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(4) A provision as follows: "Other insurance in this insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for …….. (insert type of coverage or coverages) in excess of $ …… (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate"; or in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the estate of the insured, as the case may be, and the insurer will return all premiums paid for all other such policies."

(5)(a) A provision as follows: "Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount

which the services rendered would have cost in the absence of such coverage."

(6)(a) A provision as follows: "Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

The Colorado Standard PPO and Standard indemnity policies used by the Company in its "Conversion Program" do not appear to reflect complete or correct required provisions in the following ways:

Incomplete
PPO and Indemnity Policy

- The policies do not appear to reflect the following required provisions, (identified by caption), in individual sickness and accident policies:

  1. Entire contract---changes
  2. Time limit on certain defenses
  3. Grace period
  4. Reinstatement (the Company has indicated that it provides only a limited reinstatement of coverage, within four (4) calendar days of the end of the grace period, the policy is reinstated with no break in coverage and any premium received after this four day period is refunded.) There is no wording to this effect in the policy.

Incorrect
PPO and Indemnity Policy

- The "Time of Payment of Claims" reflects an incorrect time period of sixty (60) days after receipt of written proof for payment to be made. Colorado insurance law requires clean claims received electronically to be paid within thirty (30) days and clean non-electronically received claims to be paid within forty-five (45) days after receipt of written proof.

- The policy reflects what appear to be "Group" Coordination of Benefit provisions consistent with Colorado Regulation 4-6-2. As this plan is issued as an "Individual" conversion plan, if Coordination of Benefit provisions are included the Company would need to use one of the optional provisions allowed in individual sickness and accident insurance policies as reflected in Section 10-16-203, C.R.S.

Pages 28 and 29 of the Standard PPO policy and pages 26 and 27 of the Standard indemnity policy reflect:

Part IV – COORDINATION WITH OTHER BENEFITS

Intent

The intent of Coordination with Other Benefits is to provide that the sum of benefits paid under this plan plus benefits paid under all other Plans will not exceed the actual cost charged for a treatment or service.

Definitions

As used in this Section, the term "This Plan" will mean the medical Expense benefits described in this policy.

The term Plan will mean This Plan and any medical expense benefits provided under:

a. any insured or non-insured group, service, prepayment or other program arranged through an employer, trustee, union or association;

b. any program required or established by state or Federal law (including Medicare Parts A and B);

c. any program sponsored by or arranged through a school or other educational agency; or

d. the first party medical expense provisions of any automobile policy issued under a No-Fault insurance statute, as provided below:

except that the term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need. Also, the term Plan will not include group-type hospital indemnity benefits of $100 per day or less; but will include the amount by which group or group-type hospital indemnity benefits exceed $100 per day.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

The term "Allowable Expense" will mean Maximum Allowable Fees for treatment or service when at least a part of those charges are covered under at least one of the Plans then in force for the person for whom benefits are claimed. However, the difference between the cost of a private room and the cost of a semi-private room will be an Allowable Expense only when confinement in a private room is Medically

Necessary Care. If a Plan provides benefits in a form other than cash payments, the cash value of those benefits will be both an Allowable Expense and a benefit paid.

The term "Claim Determination Period" will mean the part of a calendar year during which you or a Dependent would receive benefit payments under This Plan if this Section were not in force.

Page 34 of the Standard PPO policy and page 32 of the Standard Indemnity policy reflect:

PART VII – CLAIM PROCEDURES

Time of Payment Claims

Payments due under this policy will be paid within 60 days of receipt of written proof of loss.

Form Number	Form Name
I5-716-00073B	Colorado Mandated Individual Conversion Plan Standard PPO Plan
I5-714-00072	Colorado Mandated Individual Conversion Plan Standard Indemnity Plan

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-202 and 10-16-203, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its Standard PPO and indemnity health benefit plans reflect all required and optional provisions in compliance with Colorado insurance law.

Issue E20: Failure to reflect correct eligibility requirements for conversion coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

> (1)(c)(I) A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee, dependent, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirely or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled to have issued by the insurer a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy", *subject to the following conditions*: [Emphasis added.]
>
> (F) The insurer shall not be required to issue a converted policy covering any person if such person *is covered by medicare*. … [Emphasis added.]

The Company's application for conversion coverage requires that a "Notification of Your Right to Convert" form be received prior to processing of the application. This form incorrectly reflects that an individual is not eligible for conversion coverage if "covered or eligible" for Medicare. Colorado insurance law allows being "covered by medicare" as eliminating eligibility, but not just being "eligible" for medicare. Additionally, there is no provision in Colorado insurance law that would allow refusal of eligibility for conversion coverage if an individual was age 65 or older as is stated in this form.

The Company's Standard Indemnity and Standard PPO plans also reflect that a person is not eligible for coverage if he/she is "eligible" for Medicare rather than "covered" by Medicare.

Page 1 of the Colorado Conversion Coverage Application reflects:

> In order to process this application, we must have received your "Notification of Your Right to Convert" form.

Page 2 of the "Notification of Your Right to Convert" form reflects:

> **You <u>are not</u> eligible if:**
>
> 4. You are age 65 or older.

5. You are covered or eligible for Medicare or other medical expense benefits offered by any group plan, individual policy, prepayment plan, government program or any other plan which, according to our rules, results in excessive coverage or over-insurance.

Page 9 of both the Colorado Standard Indemnity and the Colorado Standard PPO Plans reflect:

PART II – ELIGIBILITY

A person is eligible for coverage under this policy if he/she was continuously insured under the Prior Plan for three months in a row, unless:

- The person is eligible for Medicare

Form Number	Form Name
YRYOBRO	Notification of Your Right to Convert
I5-714-00072	Colorado Mandated Standard Indemnity Plan
I5-716-00073B	Colorado Mandated Standard PPO Plan

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its application forms and policies reflect correct eligibility requirements for conversion coverage as required by Colorado insurance law.

Issue E21: Failure to reflect correct deductible amounts, coinsurance percentages and plan type titles on the conversion coverage application.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4. Rules

A. 1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation* and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., *and as conversion coverage* pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan *or to those individuals purchasing a basic conversion plan*. [Emphases added.]

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan* required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., *and for use as conversion coverage* pursuant to §10-16-108, C.R.S. [Emphases added.]

B. 1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name} [Type of plan (i.e., Indemnity, Preferred Provider or HMO) *(Basic Health Benefit Plan without Specified Mandates, Basic High Deductible Health Benefit Plan or Basic High Deductible Health Benefit Plan without Specified Mandates*)] for Colorado". [Emphasis added.]

Benefit Grid:

2004 COLORADO BASIC HEALTH BENEFIT PLANS WITHOUT SPECIFIED MANDATES:
INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS
(Please note: all coinsurance percentages listed are what the carrier will pay for the service.

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN	
BASIC HEALTH BENEFIT PLAN WITHOUT SPECIFIED MANDATES		IN-NETWORK	OUT-OF NETWORK[2]
4. ANNUAL DEDUCTIBLE a) Individual b) Family	$ 1,000 $ 3,000	$ 3,000 $ 6,000	$ 6,000 $ 12,000 (Deductibles are separate from in-network deductibles)

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN	
BASIC HIGH DEDUCTIBLE HEALTH BENEFIT PLAN		IN-NETWORK	OUT-OF NETWORK[2]
4. ANNUAL DEDUCTIBLE[2] a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	$ 2,000 $ 4,000	$ 2,000 $ 4,000	$ 4,000 $ 8,000 (Deductibles are separate from in-network deductibles)

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN	
Basic High Deductible Health Benefit Plan Without Specified Mandates		IN-NETWORK	OUT-OF NETWORK[1a]
4. ANNUAL DEDUCTIBLE[2] a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	$ 2,000 $ 4,000	$ 2,000 $ 4,000	$ 4,000 $ 8,000 (Deductibles are separate from in-network deductibles)

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN	
		IN-NETWORK	OUT-OF NETWORK[2]
4. ANNUAL DEDUCTIBLE a) Individual b) Family	$ 1,000 $ 3,000	$ 1,000 $ 2,000	$ 2,000 $ 4,000 (Deductibles are separa

			te from in-netwo rk deduc tibles)

The plan options that are reflected on the application used by the Company for conversion coverage reflect incorrect deductible amounts, coinsurance percentages and basic plan type titles.

Page 2 reflects:

PLAN OPTIONS

Choose one:

Mandated Conversion Plans:

_____	Basic Indemnity Plan:	$1,000 deductible, 50%/50% coinsurance.
_____	Basic PPO Plan:	In Network $750 deductible, 70%/30% Coinsurance. Out Network $1,500 Deductible, 50/50% coinsurance.
_____	Standard Indemnity Plan:	$500 deductible, 70%/30% coinsurance
_____	Standard PPO Plan:	In Network $300 deductible, 80%/20% coinsurance. Out Network $600 deductible, 50%/50% coinsurance

Form Number	Form Name
l5-784-00074-CO	Colorado Conversion Coverage Application

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its conversion coverage application forms reflect correct deductible amounts, coinsurance percentages and plan type titles as required by Colorado insurance law.

Issue E22: Failure to reflect only allowable exclusions for coverage of complications of pregnancy.

Colorado Insurance Regulation 4-2-6, Concerning The Definition Of The Term "Complications Of Pregnancy" For Use In Accident And Health Insurance Policies, promulgated under the authority granted to the Commissioner of Insurance under Sections 10-1-109, 10-16-109 and 10-3-1110, C.R.S., states:

> Section 4. Definitions
>
> For the purposes of this regulation "Complications of pregnancy" shall mean:
>
> (2) *Non-elective cesarean section*, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. [Emphasis added.]

The two (2) individual major medical expense health insurance policies being reviewed reflect a more limiting definition of benefits to be provided for complications of pregnancy than is allowed by Colorado insurance law. A "repeat" cesarean section could be a non-elective cesarean section which qualifies as a covered complication of pregnancy.

Page 17 of both policies under **SECTION V – EXCLUSIONS AND LIMITATIONS**, states:

> **Exclusions**
>
> *Benefits* will **NOT** be paid for *incurred* charges for the following:
>
> - Normal *pregnancy* and delivery, elective or repeat cesarean section or elective abortion;

Form Number	Form Name
I5-543-00150-CO	CeltiCare-Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic-Major Medical Expense Policy

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-6. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its policies reflect only allowable exclusions relating to complications of pregnancy as required by Colorado insurance law.

Issue E23: Failure to include a provision for continuity of care in applicable instances involving termination of coverage.

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states:

> (1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.
>
> (4)(a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).
>
> (c) In the circumstance that coverage is terminated for *any reason other than nonpayment of the premium, fraud, or abuse*, every managed care plan *shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged*. [Emphases added.]

The Company's Basic Celtic and Celticare major medical expense policies do not appear to provide for continuity of care in the event of termination of coverage that is in compliance with Colorado insurance law. There is no allowance reflected for continued care until discharge for covered persons being treated at an in-patient facility if coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse.

Page 20 of both policies reflects the following under **SECTION VI – TERMINATION OF COVERAGE:**

Coverage Terminates

All coverage terminates for an *insured person* at 12:01 a.m. on the day following the date through which your premium has been paid if any of these circumstances occurs:

- The *insured person* gives prior written notice of termination;
- The *insured person* begins living outside the United States;
- The *insured person* fails to make any required premium payments, subject to the grace period provision;
- The *dependent* ceases to be eligible under the plan; or
- The *policy* is terminated.

If there are losses for charges *incurred* in connection with a disability or medical condition that began while coverage was in force, this policy does not provide *benefits* after the *insured person's* coverage terminates.

The Policy Is Terminated

The *policy* provides continuous coverage subject to the payment of monthly premiums and all other *policy* provisions. Celtic can terminate the *policy* on the first day of any month by giving at least 31 days prior written notice to the *primary insured person.* If this occurs, coverage terminates for all *insured persons.*

Form Number	Form Name
I5-543-00150-CO	CeltiCare – Major Medical Expense Policy
I5-544-00159-CO	Celtic Basic – Major Medical Expense Policy

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-705, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its policies reflect a provision for continuity of care in required instances involving termination of coverage as required by Colorado insurance law.

Issue E24: Failure to reflect the correct number of days allowed for a break in coverage for the purpose of giving credit for previous creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. … [Emphasis added.]

Colorado Insurance Regulation: 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days.* [Emphasis added] For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. *Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail*. [Emphasis added.]

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, *if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations*. [Emphasis added.]

The Colorado application used by the Company in 2005 for its CelticSaver HSA Health Plan indicates an incorrect number of days (63) for a break in coverage to qualify for waiving of any exclusionary time periods applicable to pre-existing conditions. Colorado law prevails over the federal regulations and indicates creditable coverage may be credited and certified if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage.

Page 2 of the application reflects:

OTHER HEALTH COVERAGE

Were you or your dependents covered under any other Health Insurance plan in the last 24 months? Yes* No

*If "Yes," what type of coverage was your or your dependents last plan?
Employer Based Group Individual COBRA Other

Date of coverage from ___/___/___ to ___/___/___

As of the date of this application, have you or your dependents had a break in coverage of more than 63 days? Yes No

Form Number	Form Name
15-586-00178-CO AP10CO	CelticSaver HSA Health Plan

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its applications reflect the correct number of days allowed for a break in coverage for purposes of giving credit for previous creditable coverage as required by Colorado insurance law.

APPLICATIONS
FINDINGS

Issue G1: Failure, in some cases, to issue health insurance policies with exclusionary riders that comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (f)(XI) *Reducing benefits under a health insurance policy by the addition of an exclusionary rider, unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition*; [Emphasis added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (1) Complications of pregnancy and childbirth
>
> (a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article *shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract.* … [Emphasis added.]

From a population of seventy-three (73) policies issued with restrictive riders in 2005, a sample of fifty (50) policies was chosen for review. It was noted during the examiners' review that twenty-nine (29) of the policies appeared to have been issued with exclusionary riders that were too general and much too broad for the specific condition documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition and/or the exclusionary rider excluded a mandated benefit, or excluded a specific procedure or body part. Exclusionary riders are required to be based on actual medical history and related to a specific condition. Colorado insurance law does not allow for the exclusion of mandated benefits such as complications of pregnancy and childbirth, or the exclusion of specific procedures or body parts.

APPLICATION FILES ISSUED WITH EXCLUSIONARY RIDERS

Population	Sample	Number of Exceptions	Percentage to Sample
73	50	29	58%

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that issuance of any exclusionary riders are in compliance with Colorado insurance law.

Issue G2: Failure, in some cases, to provide CoverColorado notice forms in instances involving a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

> (1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:
>
> (a) Such individual has applied to a carrier for a health benefit plan and:
>
> (III) *Such application was accepted with a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.* [Emphasis added.]

Section 10-8-521, C.R.S., Notice to residents, states:

> *If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513(1)(a)*, or if any federally eligible individual applies to a carrier for a health benefit plan, *the carrier shall give the individual written notice that the individual may be eligible for coverage under the program*, including information about available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program. [Emphases added.]

Colorado Insurance Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states in part:

> Section 4. Rules
>
> B. Notification Requirements for Individuals with Adverse Underwriting Decisions
>
> 1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible

for coverage under the program. The adverse underwriting decisions which require the carrier to notify the applicant/insured are:

c. *Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.* [Emphasis added.]

From a population of seventy-three (73) policies issued with restrictive riders in 2005, a sample of fifty (50) policies was chosen for review. Only two (2) of the files were issued with riders reducing or limiting coverage for pre-existing conditions for six (6) months. The remaining forty-eight (48) files contained fifteen (15) riders permanently excluding coverage and thirty-three (33) files contained riders excluding coverage for periods ranging from twelve (12) months to sixty (60) months. This indicates that notice of eligibility for coverage under CoverColorado should have been sent to forty-eight (48) of the applicants. The Company was able to provide only thirteen (13) notices for the forty-eight (48) files

APPLICATION FILES ISSUED WITH RESTRICTIVE RIDERS

Population	Sample	Number of Exceptions	Percentage to Sample
73	50	35	70%

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-8-513 and 10-8-521, C.R.S. and Colorado Insurance Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that CoverColorado notice forms are sent in all applicable situations in compliance with Colorado insurance law.

Issue G3: Failure, in some cases, to provide a replacement notice when replacing another policy of accident and sickness insurance.

Colorado Insurance Regulation 4-2-1, Replacement Of Accident And Sickness Insurance, promulgated under the authority of §§10-1-109 and 10-3-1110, C.R.S., states in part:

> Section 5. Rules
>
> D. Upon determining that a sale will involve replacement of accident and sickness insurance, any issuer, other than a direct response issuer, or its producer, *shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, a notice regarding replacement of accident and sickness insurance.* One (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and *an additional signed copy shall be retained by the issuer*. … [Emphases added.]

It does not appear from a review of the fifty (50) application files that replacement notices were sent in all applicable instances. Information reflected in the applications for three (3) of the files indicate that replacement notices would have been required, but no documentation could be produced to confirm that a notice was sent.

APPLICATION FILES

Population	Sample	Number of Exceptions	Percentage to Sample
73	50	3	6%

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that replacement notices are sent in all applicable situations in compliance with Colorado insurance law.

Issue G4: Failure to use required determination and disclosure forms to allow exemption from provisions required of small group plans when offering and issuing individual plans to business groups of one.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states:

> (1)(c)(I) The provisions of this article concerning small employer carriers and small group plans *shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met*: [Emphasis added.]
>
> (A) *As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-16-102 (6).* [Emphasis added.]
>
> *(D) As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form* [Emphasis added.] stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. …

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> 5. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the

policy itself, and the application for coverage meet all the following conditions:

1. Pursuant to Section 10-16-105.2(1)(c)(I)(A), C.R.S., the carrier issuing the policy determines whether or not the applicant is a self-employed business group of one. *A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. A copy of the completed form shall be kept on file with each application*. In addition, pursuant to Section 10-16-102(6)(c), C.R.S., a carrier may require all business group of one applicants to supply certain tax and withholding documents in order to determine if an applicant meets the definition of a business group of one. Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one. An applicant who does not meet this test falls into one of two categories. Either:

    a) The applicant is a small employer that is not a self-employed business group of one and thus any plan sold to such person is subject to the small group laws of Colorado, pursuant to Section 10-16-105.2(1)(a), C.R.S.; or

    b) The applicant is neither a small employer, nor a self-employed business group of one, nor any other person covered by the small group laws of Colorado (see Section 10-16-105.2(1), C.R.S.) and thus any plan sold to such person is not subject to this regulation but is subject to the other laws of Colorado relating to individual health benefit plans. [Emphasis added.]

3. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:

    a) The carrier, as part of its application form, shall require each self-employed business group of one purchasing an individual health benefit plan pursuant to Section 10-16-105.2(1)(c)(I) to read and sign a disclosure form, as proscribed by the Division of Insurance, attesting that they understand that they are forfeiting their rights to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three (3) years after the date of

purchase, unless a small employer carrier voluntarily permits the purchase of a business group of one policy within that three-year period.

b) The carrier must provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-16-105.2(1)(c)(I)(D), C.R.S.

B. Material failure by a carrier or its representative to comply with the requirements of Part A of Section 5 of this regulation will result in individual policies sold to self-employed business groups of one becoming subject to Colorado's small group laws.

From a review of the fifty (50) application files, it does not appear that the Company has met the conditions of Colorado insurance law for its plans to be exempt from small group laws when selling individual health plans. None of the files reviewed contained a "Determination of Self-Employed Business Group of One Form" that is to be obtained from all applicants and kept on file with each application. Additionally in sixteen (16) files, although the applicant had indicated on the application that they were self-employed, there was not a signed disclosure form in any of these files.

Additionally, it was noted by the examiners during the review of the Company's forms that it had not included a disclosure form with its application forms stating that by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased. Also, the Company had apparently not adopted the required "Determination of Self-Employed Business Group of One Form" to be used when selling individual plans to business groups of one, since it was not included on the annual certification of forms in use during the examination period.

APPLICATION FILES

Population	Sample	Number of Exceptions	Percentage to Sample
73	50	50	100%

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-105.2 C.R.S. and Colorado Insurance Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that determination and disclosure forms for self-employed business groups of one applying for individual health benefit plans are provided as required by Colorado insurance law.

Issue G5: Failure to comply with Colorado insurance law by issuing conversion policies for other carriers.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

> (1) Group sickness and accident insurance – conversion privileges
>
> (c)(I) A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee, dependent, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled *to have issued by the insurer* a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy", subject to the following conditions: [Emphasis added.]

Celtic issues conversion policies which are made available to other insurance carriers, self-funded employer groups and HMOs who enter into an agreement with Celtic to provide conversion coverage to certain eligible individuals whose group coverage has terminated. A Celtic conversion policy is issued in lieu of a conversion policy offered by the original carrier, self-funded employer group and/or HMO.

This does not appear to be in compliance with Colorado insurance law. An individual is entitled to have a conversion policy issued, however it is the legal responsibility of the insurer, (i.e., the insurer providing the original group insurance to the individual whose coverage terminates), to underwrite and issue the conversion policy, and this responsibility may not be delegated to another insurer or carrier. It would be acceptable for a carrier to delegate the administration of the conversion policies to a third party (even another carrier), but the original carrier must retain the risk and ultimately bears all of the legal responsibilities related to the conversion policy.

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108 C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has discontinued the practice of issuing conversion policies for other carriers to ensure compliance with Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS/RESCISSIONS FINDINGS

Issue H1: Failure to provide CoverColorado notice forms in all required instances.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

(1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:

(a) Such individual has applied to a carrier for a health benefit plan and:

(I) *Such application has been rejected or refused because of the health or medical condition of the applicant*; or [Emphasis added]

(c) Such individual has had a health benefit plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of a premium or premiums.

Section 10-8-521, C.R.S., Notice to residents, states:

If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513(1)(a), or if any federally eligible individual applies to a carrier for a health benefit plan, the carrier shall give the individual written notice that the individual may be eligible for coverage under the program, including information about available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program. [Emphasis added.]

Colorado Insurance Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

Section 4. Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or

> she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the carrier to notify the applicant/insured are:
>
> (a) *The applicant is rejected for insurance because of the medical condition or history of the applicant*; [Emphasis added.]

The Company provided a population of two (2) policies that had been rescinded in 2005. One (1) of these files involved the insured notifying the Company of the birth of a child within three months after the effective date and the risk would not have been accepted if the medical condition of a pregnancy had been disclosed. The other file involved receipt of a claim and records being obtained during the investigation of this claim that indicated a history of alcohol dependence. If this medical condition had been known by the Company, the risk would not have been accepted. Neither of these files contained the CoverColorado notice form for adverse underwriting decisions that is required by Colorado insurance law.

Additionally, one (1) declined file in the sample of fifty (50) files had no CoverColorado notice sent to the applicant who was declined due to medical history.

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-8-503 and 10-8-521 C.R.S. and Colorado Insurance Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established necessary procedures to ensure that CoverColorado notice forms will be sent in all applicable instances as required by Colorado insurance law.

Issue H2: Failure, in some cases, to reflect correct information in certificates of creditable coverage.

Colorado Insurance Regulation: 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances *to ensure Colorado consumers receive correct certificates of creditable coverage* in a timely manner. [Emphasis added.]

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

n. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

3. The following sections of the federal regulation adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern *the method for counting creditable coverage*; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and *requirements for providing certificates of*

creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

o. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions *for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage,* if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations. [Emphasis added.]

3. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage *as long as all of the information required by 45C.F. R.146.115(a)(3), or 45C.F.R. 148.124(b)(2), as appropriate, is included.* However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation. [Emphasis added.]

From a review of the sample of fifty (50) individual plans cancelled in 2005, it does not appear that all of the certificates of creditable coverage, issued by the Company and provided to insureds whose coverage had terminated, accurately reflected the period of creditable coverage under Celtic's plans. All of the certificates included the following statement: "All individuals identified on this certification have had at least 18 months of creditable coverage." It is evident from the dates coverage began and ended, which are also indicated on the certificates, that Celtic did not provide coverage for at least 18 months for twenty-six (26) of the files.

CANCELLED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
754	50	26	52%

Recommendation No. 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that only correct information is reflected on certificates of creditable coverage in compliance with Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle claims within the required time periods.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and *within forty-five calendar days after receipt by the carrier if submitted by any other means*. [Emphasis added.]

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) *shall be paid, denied, or settled within ninety calendar days after receipt by the carrier*. [Emphasis added.]

(6) This section shall not prohibit a carrier from retroactively adjusting payment of a claim that is not subject to the provisions of section 10-16-704, if:

(a) The policyholder notifies the carrier of a change in eligibility of an individual; and

(b) The adjustment is made within thirty days after the carrier's receipt of such notification.

Data provided by the Company indicated 25,579 paid and denied claims processed by Celtic and received via paper in 2005. The examiners identified 714 claims from this population of 25,579 as taking over ninety (90) days from date of receipt to process. In the interest of expediting the examination it was agreed that a sample of fifty (50) claims only would be reviewed. Forty-seven (47) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED CLAIMS RECEIVED IN 2005 EXCEEDING 90 DAYS TO PROCESS

Population	Sample Size	Number of Exceptions	Percentage to Sample
714 *	50	47	94%

*(3% of all paid and denied claims received)

The examiners identified 1,134 claims from the total population of 25,579 paid and denied clean, paper claims, processed by Celtic as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 1,134 files. Thirty-one (31) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED CLAIMS RECEIVED IN 2005 EXCEEDING 45 DAYS TO PROCESS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,134 *	50	31	62%

*(4% of all paid and denied claims received)

Recommendation No. 34:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that all claims are paid, denied or settled within the required time periods in compliance with Colorado insurance law.

Issue J2: Failure to pay late payment interest and penalties in applicable cases.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The Company indicated that computation of late payment interest and/or penalties on claims in 2005 was a manual process and was paid concurrently with the claim. However, based on the examiners' review of the claims that were not paid, denied or settled within the required time periods, it doesn't appear that

late payment interest and/or penalties were paid in all required instances. Forty-nine (49) of the claims cited for exceeding 90 days to adjudicate were determined to have required late payment interest and/or penalties, but none was paid. Sixteen (16) of the claims cited for exceeding forty-five (45) days to process were determined to have required late payment interest, but none was paid. The procedure was reportedly automated in 2006, but was still paid on a concurrent basis.

Recommendation No. 35:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that, late payment interest and penalties are paid in all applicable instances in compliance with Colorado insurance law.

Issue J3: Failure, in some cases, to accurately process claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

(f) Unfair discrimination:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, *or in the benefits payable thereunder*, or in any of the terms or conditions of such contract, or in any other manner whatever; [Emphasis added.]

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(4) Low-dose mammography

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. *All individual* and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, *shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women*. Routine and diagnostic

> screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article *and shall not be subject to policy deductibles*. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. [Emphases added.]

Concerns were raised during the review of forms which resulted in a review of certain mammography claims. Of a total population of 149 mammography claims that were paid in 2005, nineteen (19) were selected that reflected explanation codes or comments as follows:

1) charges were applied to the deductible
2) the preventive care calendar year maximum had been exhausted
3) the routine/preventive service was not covered under the health plan
4) the benefits for this type of service had been exhausted
5) benefits paid as out-of-network and paid amounts were below the minimum benefit required by Colorado insurance law

It appears that of these nineteen (19) claims, thirteen (13) were processed incorrectly.

MAMMOGRAPHY CLAIMS PROCESSED

Population	Sample	Number of Exceptions	Percentage to Sample
149	19	13	68%

Out of a total population of 15,726 paid claims, a sample of fifty (50) claims was randomly selected. Of this sample it appears that two (2) claims were paid incorrectly. Out of a total population of 9,852 denied claims, a sample of fifty (50) files was randomly selected. Of this sample it appears that twenty-four (24) claims were denied incorrectly.

PAID CLAIMS INCORRECTLY PROCESSED

Population	Sample	Number of Exceptions	Percentage to Sample
15,727	50	2	4%

DENIED CLAIMS INCORRECTLY PROCESSED

Population	Sample	Number of Exceptions	Percentage to Sample
9,852	50	24	48%

Recommendation No. 36:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that all claims are processed correctly as required by Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure to reflect complete standards or definitions in utilization review policy and procedure documents.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

> Section 2. Purpose and Background
>
> The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review. Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information.
>
> This regulation is designed to *provide minimum standards for handling grievances* involving utilization review determinations. [Emphasis added.]
>
> Section 4. Definitions [1]
>
> A. "Adverse determination" means a determination by a health carrier or its designee that request for a benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, or is determined to be *experimental or investigational*, and is therefore denied, reduced, or terminated. [Emphasis added.]
>
> D. "Clinical peer" means a physician or other health care professional who holds a non-restricted license *in a state of the United States* and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. [Emphasis added.]
>
> P.(1) "*Urgent care request*" means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
>
> (a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or *for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently*, … [Emphasis added.]

Q. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review *shall also include reviews* for the purpose of determining coverage based on whether or not a procedure or treatment is considered *experimental or investigational* in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if *an exclusion* applies in a given situation. [Emphases added.]

Section 6. Standard Utilization Review

B. (3) For an adverse determination regarding a *prospective review decision that occurs during a covered person's hospital stay or course of treatment*, the health care service or treatment that is the subject of an adverse determination *shall be continued without liability* to the covered person until the covered person has been notified of the determination by the carrier. [Emphases added.]

E. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(a) An explanation of the specific medical basis for the adverse determination;

(c) Reference to the specific plan provisions on which the determination is based;

(d) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

(e) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided *free of charge* to the covered person upon request; [Emphasis added.]

(f) If the adverse determination is based on medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person *free of charge* upon request; [Emphasis added.]

(g) If applicable, instructions for requesting:

(h) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (e) of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (f) of this paragraph; …

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the *right to appear in person at the review meeting before designated representatives of the carrier*. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision. [Emphasis added.]

C. A complaint record entry shall be made for all voluntary second level reviews, pursuant to Section 10-3-1104(1)(i), C.R.S., and Insurance Regulation 6-2-1.

D. Within *30 days after the date of receipt of a notice of an adverse determination, a covered person may file a request* for a voluntary second level review with the carrier requesting a voluntary second level review of the adverse determination. [Emphasis added.]

E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

F. (1) With respect to a voluntary second level review of a first level review decision, a carrier shall appoint a review panel to review the request. The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2)(a) The review panel shall include a minimum of three (3) people. The panel may be composed of employees of the health coverage plan who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. However, a person who was previously involved with the grievance may be a member of the panel or appear before the panel to present information or answer questions.

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(1) The review panel *shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. The covered person shall be notified in writing at least twenty (20) days in advance of the review date. …* [Emphasis added.]

(2) Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, i*ncluding accommodation for disabilities.* In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, *video conferencing, or other appropriate technology.* [Emphases added.]

(3) If the health carrier desires to have *an attorney present to represent the interests of the health carrier, it shall notify the covered person at least twenty (20) days in advance of the review* that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own. *Within seven (7) days in advance of the review, the covered person shall inform the carrier if the covered person intends to have an attorney present* to represent such person's interests. [Emphases added.]

(4) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person pursuant to Section 10-J(6)(b), *without regard to whether the information was submitted or considered in reaching the first level review decision.* [Emphasis added.]

(5) The review panel, after private deliberation, *shall issue a written decision, as provided in Section H, to the covered person within seven (7) days of completing the review meeting.* [Emphasis added.]

(6) For purposes of calculating the time periods within which a decision is required to be made and notice provided, the time period shall begin on the date the request for voluntary second review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

H. A decision issued pursuant to Subsection G shall include:

(5)(f) A *statement describing the procedures for obtaining an independent external review of the adverse determination* pursuant to insurance regulation 4-2-21. [Emphasis added.]

The Company uses Encompass Health Management Systems to perform utilization review on its behalf. In the following instances, the "Encompass Policy and Procedure – Utilization Management pages, do not reflect complete standards for handling grievances involving Utilization Review or complete definitions of terms involved in Utilization Review

Definitions

- The definition of "Adverse Recommendation" does not provide information related to an Insured's right to request reviews for benefits denied based on experimental or investigational purposes or reviews to determine if an exclusion applies.

- The definition of a Clinical Peer does not reflect that the physician or health care professional's non-restricted license is to be in a state of the United States. The following reflects the only reference to the requirement regarding state of licensure:
  Policy section of First Level Appeals Process reflects:
  The appeal record contains, but is not limited to…
  The name, title, license number, *state of licensure* and certification specialty ….

Standards

- The description of what is to be included in the written notification letter of an adverse determination does not appear to include all the required elements.

- The description of situations involving an urgent care request does not include persons with a disability for whom the time frame of the standard review procedures would create an imminent and substantial limitation on their existing ability to live independently.

- No statement is included in any of the review procedures indicating that, if requested, the information or copies of records relevant to the covered person's benefit request reviews are to be provided "free of charge."

Prospective Review

- There does not appear to be any information concerning the notification of adverse determinations of prospective reviews that occur during an inpatient confinement or course of treatment. The procedures do not reflect the provision that services are to be continued without liability to the covered person until the required notification has been provided to both the insured and the provider rendering the service.

First Level Review

- The documents provided do not describe the procedures or timeframes allowed for obtaining a voluntary second level appeal review.

- The timeframe of *one hundred eighty days* is reflected as the time period allowed an insured person to file for a first level review of an adverse determination. If the first level review is an adverse determination and Encompass does not offer a voluntary second level review, the option left for the insured person is an External Review of Benefit Denials. Providing incomplete information to the insured and/or provider could cause confusion and problems in not meeting the time period for requesting an independent external review. A time period of *sixty (60) calendar days* after the receipt of notice of a carrier's final adverse determination, is allowed for filing for a request for an external review with the carrier.

- The document does not include a description of the procedures to be followed for obtaining an independent external review of an adverse determination if the covered person chooses not to file for the voluntary second level review, if offered.

Voluntary Second Level Review

The Company has indicated they offer a voluntary second level review; however, the document provided does not describe the procedures or timeframes allowed for obtaining a voluntary second level review:

- There is no indication that a period of thirty (30) days after the receipt of notice of a carrier's adverse determination is allowed for the covered person to file a request for a voluntary second level appeal review.

- The operational procedures do not indicate that all Voluntary Second Level Reviews are to be entered in the Company's Complaint Record.

- Nothing is reflected concerning the requirement for the Company to appoint a review panel that is to consist of minimum of three (3) people.

- There is no information provided concerning the required qualifications for those who will

compose the panel and/or participate in the review of an adverse determination.

- Nothing is reflected to indicate that the review panel shall schedule and hold a meeting within sixty (60) days of receiving a request from a covered person.

- Nothing is reflected to indicate that the covered person will be notified in writing twenty (20) days in advance of the review date.

- There is no indication that the covered person is provided the opportunity to appear in person before authorized representatives of the health carrier and that if needed, accommodations for disabilities are to be provided.

- There is no indication that the covered person who is unable to attend a review meeting is offered the opportunity to communicate with the review panel, at the health carrier's expense by conference call, video conferencing, or other appropriate technology.

- Nothing is reflected to indicate that the health carrier will notify the covered person at least twenty (20) days in advance of the review if they plan to have an attorney present at Voluntary Second Level Reviews. Additionally, there is nothing advising the covered person that they may wish to obtain legal representation and should inform the carrier seven (7) days in advance of the review if he/she intends to have an attorney present.

- Nothing is reflected concerning the requirement of the review panel to issue a written decision within seven (7) days of completing the review meeting.

Independent External Review

- The procedures do not reflect:

  The availability of an independent external review process;

  The circumstances under which a person may use such a process;

  The procedures for requesting an independent external review;

  The required deadlines associated with an independent external review.

Wording in the Company's document titled "Encompass Policy and Procedure - Utilization Management reflects the following:

Procedure Review

Definitions

Utilization Management/Utilization Review

Evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefit plan; also referred to as Utilization Review. Utilization Management programs include review of inpatient acute care services, outpatient services, skilled nursing services, diagnostic and imaging services, psychiatric chemical dependency services, rehabilitation, physical therapy, occupational therapy and speech therapy services. ENCOMPASS nurses and peer reviewers help achieve appropriate, effective, quality healthcare services by reviewing proposed and ongoing care for medical necessity.

Adverse Recommendation Review Process

Policy

An Adverse Recommendation is professional opinion by an ENCOMPASS peer reviewer (PR) that proposed treatment is not medically necessary or is not being rendered at an appropriate level of care. The peer reviewer's recommendation is based on medical information available at the time of the review. An adverse recommendation can be made for an admission, a procedure, pre-operative days, and/or an inpatient continued stay. Other types of review that have the potential for adverse recommendations, including outpatient services such as home care, physical therapy, chiropractic services, skilled nursing services, hospice care, outpatient psychiatric services, etc.

Procedure

Verbal notification is to be followed by *written notification* to the above-mentioned parties within the timeframes (refer to the Prospective Review, Concurrent Review, Retrospective Review and/or Continued Stay Review Processes.) … *Notification must include the type of review performed, the specific clinical reason for the adverse recommendation, a description of the appeal process,* which includes ENCOMPASS mailing address, telephone and fax numbers and the time frame for requesting an appeal. [Emphases added.]

Definitions

Adverse Recommendation/Determination

A decision by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Clinical Peer

A physician or other health professional that holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

First Level Appeals Process

Under "Policy" on page 1:

It is the policy of ENCOMPASS to provide an **urgent appeal for** any adverse recommendation of a hospitalization or service where the absence of medical treatment could have an immediate impact on the patient's care and may result in potential harm related to an interruption of treatment.

Definitions, page 4 reflects:

Case involving urgent care

Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations

A could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or

B in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. (**Note**: This definition is derived from the Department of Labor's definition of "claim involving urgent care.)

First, Second, and Third Level Reviews

Purpose

The purpose of this policy is to define the purpose of the ENCOMPASS review initiation request policy and procedure.

Procedure

- *Second Level Review* (Physician Peer Clinical Reviewer)

Physicians with a non-restricted license, actively practicing with full time active (non-restricted) hospital privileges are used for second level peer review. Board certified physicians may also be used.

Recommendation No. 37:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that complete standards and definitions are reflected in utilization review policy and procedure documents in compliance with Colorado insurance law.

Issue K2: Failure to have written notification of benefit denials signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states:

(1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not *medically necessary, appropriate,* effective, or efficient *unless such denial is made pursuant to this section*. [Emphases added.]

(3)(a)(I) All denials of requests for reimbursement for medical treatment, standing referrals, or other benefits on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient shall include:

(4) *All written denials of requests for covered benefits on the ground that such benefits* are *not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado.* [Emphasis added.]

The Company uses Encompass Health Management Systems as their entity to perform Utilization Review on their behalf. The written denials of requests for services for two (2) Utilization Review files in the sample of the data provided by the Company do not appear to have been signed by a licensed physician familiar with standards of care in Colorado as is required. The two (2) files were the only denial of benefits in the sample of fifty (50) files of all Utilization Review Determinations and were denied for one of the reasons that required a licensed physician's signature. The written denials of requests for services for four (4) Appeal Review files in the sample of the data provided by the Company do not appear to have been signed by a licensed physician familiar with standards of care in Colorado as is required. The four (4) files were in the sample of six (6) files for all Appeal Review Determinations and were denied for one of the reasons that required a licensed physician's signature.

Recommendation No. 38:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established the necessary procedures to ensure that all written notification of benefit denials are signed by a licensed physician in compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
COMPANY OPERATIONS/MANAGEMENT – FINDINGS		
Issue A1: Certifying and using forms that do not comply with Colorado insurance law.	1	17
Issue A2: Failure to provide a complete response to a request for claims records.	2	19
POLICY FORMS – FINDINGS		
Issue E1: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.	3	22
Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.	4	23
Issue E3: Failure to reflect the mandatory coverage to be provided for prosthetic devices.	5	25
Issue E4: Failure to include notification of the availability and a description of the independent external review procedures in or attached to policies.	6	27
Issue E5: Failure to allow benefits for covered services based on a licensed provider's status, (e.g., a family member or normally a member of the insured's or the insured dependent's household.)	7	29
Issue E6: Failure to provide credit for previous coverage for certain named conditions.	8	31
Issue E7: Failure to reflect the mandatory coverage to be provided for low-dose mammography.	9	33
Issue E8: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.	10	35
Issue E9: Failure to reflect all required information in application forms concerning replacement of coverage.	11	37
Issue E10: Failure to reflect accurate requirements to qualify as a dependent.	12	41
Issue E11: Failure to reflect the mandatory coverage for child health supervision services.	13	45
Issue E12: Failure to maintain a Colorado health plan description form required to be provided to business groups of one applying for coverage.	14	47
Issue E13: Failure to accurately reflect the coverage to be offered for home health services and hospice care.	15	59
Issue E14: Failure to reflect the mandated coverage to be provided for the treatment of cleft lip and cleft palate.	16	62
Issue E15: Failure to reflect correct or complete information on certificates of creditable coverage.	17	65
Issue E16: Failure to use one of the three required Basic health benefit plan design options as conversion coverage.	18	67
Issue E17: Failure to include accurate benefits and coverage wording in the	19	92

ISSUES	Rec. No.	Page No.
Standard PPO health benefit policy.		
Issue E18: Failure to include accurate benefits and coverage wording in the Standard indemnity health benefit policy.	20	112
Issue E19: Failure to accurately reflect the required and optional provisions in individual sickness and accident policies.	21	117
Issue E20: Failure to reflect correct eligibility requirements for conversion coverage.	22	119
Issue E21: Failure to reflect correct deductible amounts, coinsurance percentages and plan type titles on the conversion coverage application.	23	124
Issue E22: Failure to reflect only allowable exclusions for coverage of complications of pregnancy.	24	125
Issue E23: Failure to include a provision for continuity of care in applicable instances involving termination of coverage.	25	127
Issue E24: Failure to reflect the correct number of days allowed for a break in coverage for the purpose of giving credit for previous creditable coverage.	26	130
APPLICATIONS FINDINGS		
Issue G1: Failure, in some cases, to issue health insurance policies with exclusionary riders that comply with Colorado insurance law.	27	133
Issue G2: Failure, in some cases, to provide CoverColorado notice forms in instances involving a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.	28	135
Issue G3: Failure, in some cases, to provide a replacement notice when replacing another policy of accident and sickness insurance.	29	136
Issue G4: Failure to use required determination and disclosure forms to allow exemption from provisions required of small group plans when offering and issuing individual plans to business groups of one.	30	139
Issue G5: Failure to comply with Colorado insurance law by issuing conversion policies for other carriers.	31	140
CANCELLATIONS/NON-REN/DECLINATONS FINDINGS		
Issue H1: Failure to provide CoverColorado notice forms in all required instances.	32	143
Issue H2: Failure, in some cases, to reflect correct information in certificates of creditable coverage.	33	145
CLAIMS – FINDINGS		
Issue J1: Failure, in some cases, to pay, deny or settle claims within the required time periods.	34	148
Issue J2: Failure to pay late payment interest and penalties in applicable cases.	35	150
Issue J3: Failure, in some cases, to accurately process claims.	36	152

UTILIZATION REVIEW		
Issue K1: Failure to reflect complete standards or definitions in utilization review policy and procedure documents.	37	163
Issue K2: Failure to have written notification of benefit denials signed by a licensed physician.	38	164

Independent Market Conduct Examiners

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

for
The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
Participated in this examination and in the preparation of this report.